EAST REGION EMERGENCY MEDICAL SERVICES & TRAUMA CARE SYSTEM FY 2004-05 PLAN

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The East Region staff would like to take this opportunity to again thank ALL of the volunteers who are dedicated to making sure that the "right patient" gets to the "right facility" in the "right amount of time". The Regional Council, the Chairs & Executive Committee, and all of the other East Region committees have provided the technical assistance necessary to administer an effective EMS and trauma system in a region that covers over 15,536 square miles (not including Columbia County).

Thank You!

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I. AUTHORITY

A. AUTHORITY: This plan is authorized under RCW70.168.015(7) "Emergency medical services and trauma care system plan: means a state-wide plan that identifies state-wide emergency medical services and trauma care objectives and priorities and identifies equipment, facility, personnel, training and other needs required to create and maintain a state-wide emergency medical services and trauma care system. The plan also includes a plan of implementation that identifies the state, regional and local activities that will create, operate, maintain and enhance the system. The plan is formulated by incorporating the regional emergency medical services and trauma care plans required under this chapter…"

Periodically there are legislative non-funded mandates that may cause hardship to some of the rural licensed prehospital agencies in the region. An example would be the mandate that took effect on January 1, 2002 (WAC 246-979-300) that required: "Defibrillation capability appropriate to the level of personnel". Many rural prehospital providers in this region have little or no EMS operating budgets. The majority of rural agencies rely on the $1,200 participation grants that are awarded annually by the Department of Health in order to purchase basic equipment necessary to provide patient care. Funding was not available to purchase the mandated defibrillators.

This particular non-funded mandate ("Defibrillation capability appropriate to the level of personnel") also effected the Regional Council's administration. The Department of Health, in partnership with the eight EMS regions in the state, collaborated on a federal AED grant that would allow 17 AEDs per region to be distributed to EMS, law enforcement and the public. In the first year of the grant, administrative support went to the Department of Health but none went to the EMS regions.

The East Region EMS/TC Council has a very "bare bones" operational budget that covers specific contract deliverables and does not allow for participation in non-funded projects outside of the contract language.

B. MISSION STATEMENT: Our mission is to establish and promote a system of emergency medical and trauma services, which provides for timely and appropriate delivery of emergency medical treatment for people with acute illness and traumatic injury.

We recognize the changing methods and environment for providing optimal emergency care under the varied conditions throughout the State of Washington.

C. REGIONAL COUNCIL STRUCTURE

There are seven working committees consisting of volunteers that provide leadership for the Regional Council. They are: Communications, Injury Prevention and Public Education, Hospital Planning, Rehab, Training & Education, Prehospital & Transportation, and Information Technology. There are also four administrative committees consisting of volunteers that provide leadership for the Regional Council. They are: Finance, Bylaws, Membership, and Chairs & Executive.

II. INTRODUCTION

A. SUMMARY OF PROPOSED CHANGES

1. There are no changes to the recommended min/max numbers of verified Prehospital services.

2. There are no recommended minimum/maximum changes to the recommended trauma services or rehabilitation services.

3. The Interfacility Agreement list in Patient Care Procedure #4 Interfacility Transfer Agreements has been eliminated. There is no change to the PCP.

4. There are no recommended higher than state minimum requirements.

B. EXECUTIVE SUMMARY

The East Region is the largest geographical EMS & Trauma Care region in the State of Washington. It is comprised of 15,536 square miles and includes nine counties: Adams, Asotin, Ferry, Garfield, Lincoln, Pend Oreille, Spokane, Stevens and Whitman. Eight of the nine counties are rural and 86% of the prehospital providers are volunteer associated with agencies that have little or no monetary funding to support EMS and Trauma.. Lewiston Fire Department, a Washington State verified ALS transport service and St. Joseph's Regional Medical Center, a Level II trauma center, both located in Lewiston, Idaho, service the southern counties of the region.

An all volunteer Regional EMS and Trauma Care Council is responsible for planning and implementing the East Region EMS and Trauma Care System.. The Regional Council consists of community professionals from diverse backgrounds involved in the system of care for EMS and trauma patients within the region.

There are seven working committees consisting of volunteers that provide leadership for the Regional Council. They are: Communications, Injury Prevention and Public Education, Hospital Planning, Rehab, Training & Education, Prehospital & Transportation, and Information Technology. There are also four administrative committees consisting of volunteers that provide leadership for the Regional Council. They are: Finance, Bylaws, Membership, and Chairs & Executive.

The FY04-05 EMS and Trauma Care System Plan is the work of the Regional Council's membership and committees and describes the Region's issues and plans to address them over the next two years. The sections of the Plan address the following system components as identified by numbering in the plan.

III. Injury Prevention & Public Education: Initially the East Region had IPPE specialists to promote projects. In FY 02 the council determined that its real goal was administrative rather than operative. The emphases changed from doing projects out of the East Region EMS office to a regional IPPE program that utilizes partnering with other agencies involved in the region. The intent of the process is to ensure that IPPE is provided region-wide through community partnerships. Based on data provided by the Department of Health the East Region will partner with the regional QI Committee and the Spokane Regional Health District to fund a Falls Prevention project.

IV. A. Communications: An essential system component within the region.

a. Public Access: A Citizen Access and Affiliate EMS Agency System Policy was developed in 1998.

b. Dispatch

- Training for dispatch personnel: The Regional Council provides EMD training at least every other year, but bases the availability upon needs of the communications centers. The Regional Council adopted Clawson Emergency Medical Dispatch as the regional standard in 1995. Through this program dispatchers and call takers who complete the course become nationally certified through the National EMD Academy. Approximately 28% of dispatchers and call takers regionwide are not EMD nationally certified.

- Dispatch prioritizing: Those communications centers with EMD trained personnel are qualified to provide dispatch prioritizing.

- Provisions for bystander care w/dispatch assistance: Spokane, Stevens and Whitman Counties are currently the only counties that provide provisions for bystander care. The other counties in the region are to small to be able to provide this type of service.

- PCPs developed to improve communications: Standard 4 of PCP #1 Dispatch of Medical Personnel identifies that communications centers shall adopt an EMD Program that meets the Washington EMD Program and Implementation Guidelines.

c. Primary and alternative communication systems: There is no hospital-to-hospital communications in this region. Prehospital to hospital communications is good, however there are still many dead spots where providers cannot

contact a designated trauma center. HEAR VHF communications system is the primary communications system used in this region. Cell phones are used in many of the areas of the region, however not all counties have enough cell towers to provide this service. Some communications are relayed between hospital and prehospital through the dispatch center, local police agencies on-scene to relay to dispatch, or Amateur Radio Emergency Services (A.R.E.S.) HAM.

d. System Integration/Communication in Incidents with Varying Numbers of Patients: As a multi-patient incident grows in size and scope there exists a potential that some responding agencies may not be able to communicate with other agencies due to lack of available radio frequencies. There are still places where there are no communications.

e. Roles of Other public and private agencies: Fairchild AFB route 911 calls from the public to Spokane →Spokane E-911 notifies police→ police notify military police for initial injury →Fairchild Fire Department is notified if the call is fire or EMS related.

f. Evaluate communication system providers and dispatch activities: Since Medical Program Directors nor the DOH have the authority to provide or oversee quality improvement, most communications centers develop and implement their own policies for evaluating the effectiveness of their communications system.

B. Medical Direction of Prehospital Providers: Not all EMS providers know how to access Regional Patient Care Procedures, County Operating Procedures or county protocols. The Regional Council will expand its website to provide this information as well as other information necessary to enhance patient care.

C. Prehospital EMS & Trauma Services: 83.8% of all EMS providers in the region are volunteers. Licensing and Certification data indicates a loss of 10 providers between 2001 and 2003.

Training is provided through a contractual agreement between the Regional Council and the Inland Empire Training Council. Lack of funding is the priority need for training of EMS providers, especially in the rural counties. The Regional Council has consistently spent $101,780 on CME/OTEP annually. There has not been an increase in funding since 1992. The Regional Council has consistently applied for outside grant funds to provide enhanced training, however funding is hard to find. It is estimated that it will take approximately $367,960 to provide the necessary EMS training to providers in the rural counties of the region during this biennium. **The Regional Council is pursuing the possibility of using teleconferencing for training where hands on training is not necessary**

D. Verified Aid and Ambulance Services: There are 68 verified agencies in the East Region. There are four agencies from Idaho that are licensed in Washington. Lewiston Ambulance provides ALS service to Clarkston Fire Department in Clarkston, WA. There is a need to complete the Adams County Need and Distribution of Services document this year. Prehospital agencies have identified needs in equipment, training, and communications. Minimum/Maximum recommendations for verified services are provided at the end of this section.

E. Patient Care Procedures (PCPs) and County Operating Procedures (COPs): County Operating Procedures are not being updated and maintained as often as they should be. Regional Patient Care Procedures are reviewed annually and if revised, submitted to the DOH for approval. Once approved, PCPs and COPs are distributed regionwide for implementation. The Inland Empire Training Council also provides education annually to rural prehospital providers.

F. Multi County Or County/Inter-Regional Prehospital Care: There is a need to assess mutual aid agreements for multi-county and or county/inter-regional prehospital patient care. The Regional Council requires its county EMS/TC councils to review and revise mutual aid agreements at least every other year. This will be the year to assess the needs of mutual aid outside of county and regional boundaries.

V. Designated Trauma Care Services: All health care facilities that meet the trauma designation requirements are designated trauma centers. Annually the Regional Council reviews minimum/maximum recommendations to determine if changes are necessary. There have been no changes to the currently recommendation for a number of years. Nine of the 26 critical access facilities in the state are located in the East Region. All 22 hospitals in the region underwent assessments for Bioterrorism preparedness this last year. Rural hospital providers must travel long distances to receive training.

VI. Data Collection: Prior to the change in submission requirements on July 1, 2001, the East Region was very successful in the collection of medical and trauma data. Data is not currently being collected by the Regional Council as it has in the past. The goal for this next biennium is to develop a process for submission of prehospital trauma data to the state data registry.

VII. EMS & Trauma System Evaluation: The Regional Council is not actively involved in the QI Committee. There is a position on the QI Committee for the Regional Council President or his/her designee. The Regional Council will seek QI Committee Assistance in planning meetings so that regional participation will be enhanced. A forum needs to be developed collaboratively by both the QI Committee and the Regional Council for sharing of data and recommendations. Hospitals require additional Report Writing classes. QI meetings have been held via video conferencing during this past year. The meetings have been very successful.

III. INJURY PREVENTION & PUBLIC EDUCATION

A. REGIONAL IPPE PROGRAM

EAST REGION INJURY DATA

Washington State Department of Health Injury Prevention Program statistics reveal from 1997-2001 throughout the east region area there were:

Non Fatal Injury Hospitalization	Rural	Spokane	Rank	Fatal Injuries	Rural	Spokane	Rank
Falls	2550	10,148	#1	Suicides	97	382	#1
Suicide Attempts	2866	1583	#2	MVT-Occupant	122	305	#2
MVT - Occupant	2280	1701	#3	Falls	50	286	#3
MVT/pedal cyclist or Pedal-cyclist other injuries	357	308	#4	6 MVT/pedal cyclist or Pedal-cyclist other injuries	0	6	#4

Source: DOH, EMS & Trauma Prevention 2003

1. General Need Statement

The Regional Council has played a leading roll in providing Injury Prevention & Public Education (IPPE) for over a decade. The East Region volunteer IPPE Committee provides expertise in the development and implementation of regional projects. In addition to the Regional Council IPPE projects, many other organizations are also providing this service within the nine-county region. In spite of efforts by IPPE specialists within the region, the statistics show that there are still issues that need to be addressed. These require ongoing involvement from the Regional Council.

In 2001 the Regional Council determined that its role in IPPE was administrative only. The emphases changed from doing projects out of the East Region EMS office to a regional IPPE program that utilizes partnering with other agencies involved in the region. The intent of the process was to ensure that IPPE was provided region-wide through community partnerships. In 2003 the Regional Council reviewed the accomplishments under this model and found that rural counties of the region did not receive programs as anticipated..
The East Region has maintained a Regional IPPE Library since 1992. With the program change in 2002 IPPE materials have been moved to and incorporated into the Spokane Regional Health Districts' IPPE Library. Based on regional data and the recommendation from the regional QI Committee, the Regional Council has acknowledged the number 1 IPPE priority regionwide for FY 04 is Falls Prevention.

Over the last 4 years the regional QI Committee has identified falls as the number 1 injury for nonfatal hospitalization and the number 3 cause of fatal injuries. Motor vehicle crashes are the second leading cause of nonfatal injury hospitalization and the leading cause of fatal injuries. Head injuries due to bicycle crashes rank number 4 for both nonfatal injury hospitalization and fatal injuries.

Program stability is based on the ability to access outside grant funding. The Regional Council has allocated $38,000 and the regional QI Committee has allocated $5,000 to promote Falls Prevention region-wide in 2004.

Professional development of additional IPPE specialists in the rural areas of the region is also dependent upon funding. In the rural areas, many EMS volunteer providers are also involved in IPPE. Although the volunteer commitment is very high in the region, time is scarce. Funding for training and travel reimbursement is a necessity.

FALLS PREVENTION PROJECT

1.1. Need

From 1997 through 2001 there have been 50 fatalities and 12,698 non-fatal hospitalizations due to falls in the East Region area. Falls are the foremost cause of non-fatal injury hospitalizations in the East Region, leading motor vehicle crashes. Falls rank third for fatal injuries preceded by suicides and motor vehicle crashes. For the older person, a fall may cause pain and injury, and also ruin quality of life. Falls can cause loss of independence with over 40% of admissions into nursing homes triggered by a fall. For the over 65 age group, most falls occur when performing everyday activities in the home, yet 30% to 40% of these falls *could* be prevented.

2.1.Goal: Preventable Premature Death And Disability Due To Falls Is Reduced In The Region Through IPPE Efforts

Objective 1: ***During FY 2004 extend SRHD's Falls Prevention activities throughout the East Region rural counties***.
Strategy 1: Contract with Spokane Regional Health District back billable to July 1, 2003.
Strategy 2: Develop Falls Prevention Program to be delivered to the rural eight counties of the east region.
Strategy 3: Budget funding.
Strategy 4: Identify new project name to be proposed to and approved by East Region IPPE Committee.
Strategy 5: Identify rural county liaisons to aid in the delivery of falls prevention program.

Objective 2: ***Implement the new project in the biennium through the Spokane Regional Health District.***
Strategy 1: Conduct falls prevention education workshops to include emergency-response personnel and adult and youth service agencies in 2003-2004 in the eight rural counties of the region.
Strategy 2: The project coordinator will make falls prevention presentations to the eight rural counties of the region.

Objective 3: ***Evaluate the project by the end of FY04***
Strategy 1: Review the Spokane Regional Health District performance by June 2004.
Strategy 2: Utilize Pre & Post testing of participants through written questionnaires.

Objective 4. ***Monitor rate of falls within the region annually***
Strategy 1: Compare regional falls rates.
Strategy 2: Identify fall rate statistical resources and availability.
PROJECT COST

Total Estimated Biennium Cost: $76,000 (budgeted by Regional Council) for rural areas outside of Spokane County.

Barrier 1: Continued lack of adequate funding to support and enhance the project.
Barrier 2: Lack of volunteers for presentations would limit the process.

3. Activity Measurements: All project objectives are measurable.

IV. PREHOSPITAL

A. COMMUNICATIONS

Communications is an essential system component within the East Region. Although well developed, there are still needs to be addressed.

1.a. Public Access (e.g. 911, etc.)

A Citizen Access and Affiliate EMS Agency System Policy was developed and approved by the Regional Council in 1998. This policy is on file in the office.

1. **Need:** No issues, needs and or weaknesses have been identified

1.b. Dispatch:

1) **Training For Dispatch Personnel:** The Regional Council has identified the preferred regional standard of training as the Clawson Emergency Medical Dispatch (EMD) program. Dispatchers and/or call takers who successfully complete the Clawson Emergency Medical Dispatch course automatically receive national certification from the National Academy of EMD.

1. Need: Not all communications center personnel in the East Region are currently EMD trained.

2. Goal: By Regional Consensus All Dispatchers Will Be Nationally Certified In Emergency Medical Dispatch

Objective 1: ***Certify all Dispatchers and call takers for all dispatch agencies in Emergency Medical Dispatch (EMD) by 06/30/05.***

Strategy 1: Survey communication centers for EMD training needs annually.

Strategy 2: Provide EMD training based on survey needs.

Strategy 3: The Communications Committee will determine location of class based on location of students.

Projected Cost : $16,200 per class (includes travel, wages, registration fee and instructor fee)

Barriers – none identified as critical

2) Dispatch Prioritizing –Those communication centers in the region with EMD qualified dispatchers and/or call takers are qualified to provide dispatch prioritizing. Dispatch prioritizing can only be done if all dispatchers are trained and qualified in EMD. Currently 28% of all dispatchers/call takers regionwide are *not* EMD certified. The counties with the highest percentage of non-trained personnel are in Adams and Asotin Counties. Both of these counties

dispatch for multiple agencies such as fire, law, jail and city as well as EMS. Adams County is making an effort to EMD train their dispatchers and call takers by providing EMD training within their own county.

3) Provisions For Bystander Care With Dispatch Assistance – Dispatch assistance for bystander care is a formalized training program incorporated into the EMD class, reinforcing the need to have all dispatchers EMD trained and qualified. Spokane, Stevens and Whitman Counties are the only counties that are large enough to provide this service. The other 6 counties are very rural and too small to provide bystander care with dispatch assistance.

4) Patient Care Procedures (PCPs) / County Operating Procedures (COPs)

The East Region has three PCPs related to communications/dispatch. They are:

Patient Care Procedures # 1 – Dispatch of Medical Personnel
Patient Care Procedures # 3 – Trauma Triage and Transport
Patient Care Procedures # 6 – EMS/Medical Control Communication

The 4th standard identified in PCP #1 states: ***Communication/Dispatch Centers charged with the responsibility of receiving calls for Emergency Medical Services shall develop or adopt an EMD (Emergency Medical Dispatch) Program that meets the Washington EMD Program and Implementation Guidelines.***

1.c. Primary And Alternative Communications Systems:

1. Need: Reliable communications between prehospital providers and hospitals and hospital to hospital does not exist in all areas of the region.

- The HEAR VHF communications system is the primary communications system used in the East Region. It allows all prehospital providers to make contact with dispatch and medical control. There are still some areas of the region that have difficult reaching dispatch or medical control.
- The Washington State Patrol provides the current backup/alternative communications system. An alternate communications system would be the use of cell phone radio relay through dispatch, normal established telephone systems, cell phone direct to the hospital or relayed through the dispatch center, local police agencies on-scene to relay to dispatch, or Amateur Radio Emergency Services (A.R.E.S.) Hams.
- The only place where hospital-to-hospital communications exist is primarily in Spokane County.

2. Goal: See 1.d below.

1.d. System Integration /Communication In Incidents With Varying Numbers Of Patients):

1 Need: As an incident grows in size and scope there exists a potential that some responding agencies may not be able to communicate with other agencies due to lack of available radio frequencies. There are still places within the region where communications of any kind are unavailable.

2. Goal: Communications in EMS incidents (hospital-to-hospital and prehospital-to-hospital) are reliable and well coordinated regardless of the number of patients or agencies involved.

Objective A. ***Identify and put in place a planning process to ensure uninterrupted prehospital to hospital and/or hospital-to-hospital communications region wide by 06//30/05.***

Strategy 1: Survey stakeholders needs in each county in 2004

Strategy 2: Integrate data gained in discussions with individual counties into the communications section of the plan in 2005

Strategy 3: Look beyond VHF radio use as the only source of reliable communications. Consider, integration of cellular phones, satellite phones, UHF frequencies, and other possibilities.

Strategy 4: Collaborate with other regions and state organizations (where applicable) to insure seamless communications across regional borders.

Strategy 5: Reconvene stakeholders meeting to review draft plans in 2005.

Projected cost – unknown

Critical Barriers – no critical barriers are known

A description of system operation during single patient, multiple-patient, mass casualty and disaster incidents, identifying ambulance to ambulance, ambulance to dispatch, and ambulance to hospital communications systems follows:

Single Patient

Single patient, multiple-patient, mass casualty and disaster incidents are handled in much the same way when the call is received at the 9-1-1 centers.

1. Spokane County calls from the 9-1-1 Center are transferred to Spokane City Dispatch where all fire and EMS/TC calls are routed to the appropriate licensed/verified prehospital agency (first responder or ambulance).

2. In Spokane County, during a mass casualty or disaster, the Spokane City Dispatch Center would dispatch in the following order: 1) First Responder/Ambulance; 2) Police Department; 3) Deaconess Medical Center (Area hospital coordinator for disaster/mass casualty); and 4) Department of Emergency Management.

3. Rural Counties Dispatch: In the seven rural counties of the region, 911 call taking and dispatch is done through the Sheriff's Departments. The 9-1-1 centers are responsible to alert and/or dispatch police, fire and EMS units. Response modes (code/no code) are determined by County Operating Procedures, which relate to the Regional Patient Care Procedure #1 - Dispatch of Medical Personnel. Those calls that are not dispatched through the Sheriff's Departments are dispatched through the 9-1-1 centers.

4. Deaconess Medical Center (also a joint level II designated facility) would begin coordinating area hospitals to determine availability/inventory of all area hospital beds and services. Smaller rural designated trauma centers would also call the area joint level II designated trauma center that is on-call, for this information.

5. Mutual Aid Agreements: In most counties, dispatchers and call takers know which agencies have mutual aid agreements and dispatch accordingly. Spokane County has mutual aid preplanned and programmed into CAD. Spokane County E 9-1-1 then makes a CAD entry to alert Law Enforcement for Mutual Response.

6. Police: In Spokane County, 9-1-1 monitors incoming calls after transfer to the Spokane Fire Department Combined Communications Center.

7. Department of Emergency Management: It is the responsibility of the Department of Emergency Management to coordinate all services needed in times of mass casualty and/or disasters.

This system has weaknesses as listed earlier but works as well as can be anticipated with a single patient. The same is not true for multiple patients.

Multiple Agency On-Scene Communications: There are approximately 100 to 150 different agencies in the East Region who responds to EMS and trauma calls. Multiple agency on-scene communications refers to a function of the radio for mutual aid and use of a common frequency (districts sharing radio frequencies). For example, in Spokane County, American Medical Response accesses the fire districts First Responder tactical frequency. There is also shared use of frequencies with the Washington State Patrol. However, as an incident grows in size and scope there exists a potential that some responding agencies may not be able to communicate with others. See 1c and 1d above.

Mass Casualty And Disaster Incidents

Area hospitals using the HEAR frequency (that is 144.280) will coordinate patient care and destinations. Local Departments of Emergency Management Services will assist in bringing in out of area resources. Local fire and EMS responders are training together and entering into mutual aid agreements for more timely response.

In addition, Spokane hospitals have been piloting RAMSES, the computerized software that alerts prehospital providers and other hospitals of department availability. The hospitals are discussing common terminology and will continue to meet to address issues of RAMSES. Each facility is working on their individual red and yellow status meanings. Compliance and legal

personnel will be reviewing the hospital recommendations. They have found that RAMSES is a great teaching tool by putting updates, policies, procedures and web links on it for all to see and use.

The true limitation to the system is the HEAR radio (system). Each radio has one frequency for hospital-to-hospital contact and one frequency for pre-hospital to hospital contact, unfortunately both frequencies cannot be used simultaneously.

Quality Management – *Description of the process for evaluating communication system providers and dispatch activities, including identifying strategies for upgrading current communication system(s) follows.*

Prior to 1995 each communication center in the region provided its own way of evaluating communication system providers and dispatch activities. When the Regional Council began to sponsor EMD training region-wide, dispatchers began to learn about the technical/legal aspects of Emergency Medical Dispatch. Since that time supervisors in dispatch centers have become more aware of quality management of their providers and dispatch activities.

The Department of Health, EMS & Trauma System has approved Washington State Guidelines for Emergency Medical Dispatch. These guidelines outline suggestions for quality management of providers and dispatch activities. These guidelines will be beneficial in communication centers establishing quality management of providers and dispatch activities. Even more beneficial to patient care would be the adoption of a statewide standard of training for all EMS dispatchers, which is addressed earlier in this document.

Since EMD does not fall under the responsibility of the Department of Health, EMS & Trauma System, nor its Medical Program Directors, most communications centers within the region have developed their own process for evaluating the activities and providers within their own organization.

1.e. Other Public & Private Agencies:

- Fairchild Air Force Base

  The public calls 911… → the calls go to Spokane→Spokane 911 notified police → police notify military police for initial injury → Fire Department at Fairchild AFB is notified if the call is fire or EMS related.

- Spokane Indian Reservation – BIA police in Wellpinit

1. Need: None have been identified

2. Goal: No goals are identified

1.f. Evaluate Communications System Providers & Dispatch Activities – TABLE A follows.

TABLE A.
EVALUATION OF COMMUNIATOIN SYSTEM PROVIDERS & DISPATCH ACTIVITIES

		Adams	Asotin	Ferry
	Survey Questions	***Adams County 911***	***Asotin County 911***	***Ferry County 911***
1	Citizen Access	None	E-911	E-911
2	Consolidated Centers	Yes, fire, law and EMS	Yes, city, county, fire, EMS & jail	Yes, fire, EMS & police
3	Number of Employees	10	10 cross-trained	9
4	Number of Employees Not Trained	*None are EMD trained*	8 are not EMD trained	7
5	Kinds of Training	Criminal Justice Required Training	CJT, Call Taker I and some II	3-day initial when recertifications are due
6	Frequency of Training	40 hours per year	Required only	N/A
7	On-going Training & Certification	No EMD Training or Certification	None	Yes, NAEMD
8	Kinds of Protocols	No EMD Protocols	Internal protocols	Medical Priority Protocols
9	Medical Director Involvement	None	None	None to date. New MPD will be visiting in 7/2001.
10	Dispatch Prioritizing	None - agency is too small.	medical, fire, law no EMS	None to date. New MPD will be visiting in 7/2001.
11	Bystander Care	None	None	None to date. New MPD will be visiting in 7/2001.
12	Pre-arrival Instructions	None	None	Yes
13	Quality Assurance	None	None	No, but plan to start. Currently through county EMS council.

		Garfield County	Lincoln County	Pend Oreille County
	Survey Questions	***Sheriff's Department***	***Sheriff's Department***	***Pend Oreille 911***
1	Citizen Access	E-911	E-911	E-911
2	Consolidated Centers	Fire, Police, EMS all consolidated	Yes, fire, law and EMS	Yes
3	Number of Employees	8	9	Currently 9. Generally have 11
4	Number of Employees Not Trained	1 new employee soon-to-be trained	3	All 9 are EMD trained
5	Kinds of Training	Various	Various	Various
6	Frequency of Training	As needed and/or required	As needed and/or required	Monthly
7	On-going Training & Certification	Yes, NAED	Yes, NAED	Yes, NAEMD
8	Kinds of Protocols	Medical Priorities	Medical Priorities	Medical Priorities
9	Medical Director Involvement	No	No	Yes. Old Medical Director gone. New one coming soon.
10	Dispatch Prioritizing	Too small for dispatch prioritizing	No	No
11	Bystander Care	Yes	Yes	Yes
12	Pre-arrival Instructions	As needed	Yes, if caller stays on the line	Yes
13	Quality Assurance	Yes	Yes	Yes, Internal

TABLE A.
EVALUATION OF COMMUNIATOIN SYSTEM PROVIDERS & DISPATCH ACTIVITIES

	Spokane		
Survey Questions	***Spokane County 911***	***AMR***	***Fairchild***
Citizen Access	E-911	999 Fire	Fire, EMS as dispatched by base police
Consolidated Centers	Yes	No	Yes
Number of Employees	18	12	4
Number of Employees Not Trained	0	5	3
Kinds of Training	Various	Various	Various
Frequency of Training	Weekly	Monthly/Yr.	Monthly Review
On-going Training & Certification	Yes	Nat'l Registry	No
Kinds of Protocols	EMD, Pro-QA, SOPs	Medical Priorities	Encouraged but not required
Medical Director Involvement	Yes - Part time	No	N/A
Dispatch Prioritizing	PRO-QA suggested responses	Alpha, Bravo	Based upon level of injury. Dispatchers are EMT-B Trained
Bystander Care	Yes	Yes	No
Pre-arrival Instructions	Yes	Yes	Yes
Quality Assurance	Yes	Yes	Yes

	Stevens County		**Whitman County**
Survey Questions	***Stevens 911***	***Spokane Indian Res.***	***Whitcom***
Citizen Access	E-911	911	Yes, September 1, 2001
Consolidated Centers	Yes	No	Yes
Number of Employees	Normally 14 - Currently 11	5	14
Number of Employees Not Trained	2 are currently in training	5	0
Kinds of Training	Required, single subject	N/A	Various
Frequency of Training	Weekly, Monthly, Annually as needed	N/A	2-years
On-going Training & Certification	Yes, NAEMD & Criminal Justice Training	BIA Requirements	Yes
Kinds of Protocols	Medical Priorities	BIA Law Enforcement	Medical Priorities
Medical Director Involvement	Yes	Police does Fire and Amb.	No
Dispatch Prioritizing	Concept of Alpha Bravo used but not words	N/A	Alpha, Bravo
Bystander Care	Yes, NAEMD	No	No
Pre-arrival Instructions	Yes	No	Yes
Quality Assurance	Yes - Now using NAEMD	No	Yes, sometimes but it is not yet official.

B. Medical Direction

Medical direction includes off-line and on-line processes.

Off-Line Medical Control

Off-line Medical Control is defined in each county's protocols. "Prehospital patient care protocols" are the written procedures adopted by the MPD under RCW 18.73.030(13) and 70.168.015(26) that direct the out-of hospital emergency care of the emergency patient that includes the trauma care patient. These protocols are related only to delivery and documentation of direct patient treatment.

In the East Region some MPDs have developed patient care protocols for EMS personnel to follow with regard to patient care. Others have chosen to not write protocols and have instead implemented the protocols developed by the Department of Health. At the direction of the County Medical Program Director, prehospital providers implement the protocols in situations where communications are not available or not required with on-line medical control.

1. Need: Information on approved Regional Patient Care Procedures and County Operating Procedures, as well as county protocols is not always distributed to the prehospital provider in a timely manner. This is due at least in part to the fact that protocol changes are made randomly and not all EMS providers attend all training sessions especially in areas where there is predominately volunteer staffing.

2. Goal 1: All Agencies Can Access County Protocols, County COPS And Regional PCPs.

Objective A: ***By 06/30/04 identify a mechanism to have individual county protocols, Regional Patient Care Procedures (PCPs) and County Operating Procedures (COPs) available on the Internet (East Region's web site).***

Strategy #1: The Regional Prehospital & Transportation Committee will canvas stakeholders from each county to determine current distribution methods.

Strategy #2: County stakeholders will be queried about participating in a regionwide protocol website.

Strategy #3: Develop an implementation plan based on information gathered from stakeholders.

Strategy #4: Work with Webmaster to ensure that all documents are listed on the East Region web site.

Project Cost: $1,500

Critical Barriers – No critical barriers are known

2. Goal 2: All East Region EMS Providers are Aware Of The Off-Line Medical Control Resources That Are Available.

Objective A. ***Annually, in December, the Regional Council office will notify all agencies in the East Region of the available resources such as written PCPs, online copies of PCPs, COPs and protocols.***

Strategy #1: The Regional office will send postcards to each prehospital agency and local council in the region. The postcards will list the various ways that County Protocols, COPs and Regional PCPs can be accessed.

Projected Cost – $300

Critical Barriers – No critical barriers are known

2. Goal 3: The East Region has a Uniform Set Of Protocols, And County COPs For People Working Across Traditional Political Boundaries.

Objective A: ***The Prehospital Committee will work with County MPDs, local EMS/TC councils, and DOH to develop a strategy for implementing region-wide protocols and COPs by 06/30/05.***

Strategy #1: Survey region to identify representatives of the stakeholders listed above.

Strategy #2: Invite MPDs and other interested parties to participate in a meeting to discuss a uniform set of protocols, and County COPs. Facilitate additional meetings if necessary.

Projected Cost: Cost would depend on the Regional Council's willingness to provide reimbursement for travel expense, which could be in excess of $500 for one meeting.

Critical Barriers: No critical barriers are known

On-line Medical Control

On-line medical control may be authorized by the Medical Program Director and may be any place prehospital providers are instructed to call for on-line medical control. In many cases, it is a health care facility that has received trauma designation. On-line medical control is where a prehospital provider may speak directly with a physician delegate regarding patient care and delivery. Medical Program Directors may delegate responsibility to other physicians in accordance with WAC 246-976-920.

In the East Region prehospital providers are instructed to contract on-line medical control (at the highest level trauma designated facility that can be reached within 30 minutes) for direction on how to treat a trauma patient. Medical control is generally contacted by radio on the HEAR system, however there are instances when cell phones are used to contact medical control. Rural prehospital providers use the means for contacting the designated facility that works best for

them in their specific circumstances. Unfortunately there are many areas within the region where there is no way the reach on-line medical control by HEAR radio or by cell phone.

1. Need: Prehospital providers should be able to make contact with staffed hospital base stations at least 90% of the time. Today that is not the situation in the East Region. There are many identified communication "dead spots" in every county of the region. Lack of funding to support enhanced communications has presented a critical barrier to regional improvements.

2. Goal: EMS Providers Regionwide Can Make Contact With Staffed Hospital Base Stations at least 90% Of The Time for on-line medical control.

Objective A: ***The communications committee will identify, by 01/30/05, the areas in the region where HEAR radio transmission to the hospital base station is not normally possible for use in communication planning during the biennium***.

Strategy #1: Survey region to identify representatives of the stakeholders. Representatives may be from EMS agencies, 9-1-1 centers, hospitals and other regional patient care centers.

Strategy #2: Invite stakeholders to participate in regionwide meetings to discuss communications issues.

Strategy #3: Seek outside funding by working with state organizations and other resources to promote good regionwide prehospital-to-hospital communications.

Projected Cost: Cost would depend on the Regional Council's willingness to provide reimbursement for travel expense, which could be in excess of $500 for one meeting.

Critical Barriers: Funding for system upgrades.

IV.C.1.a. PREHOSPITAL EMS & TRAUMA SERVICES

1.a A. Current EMS/TC Personnel Resources By County And Level Of Training

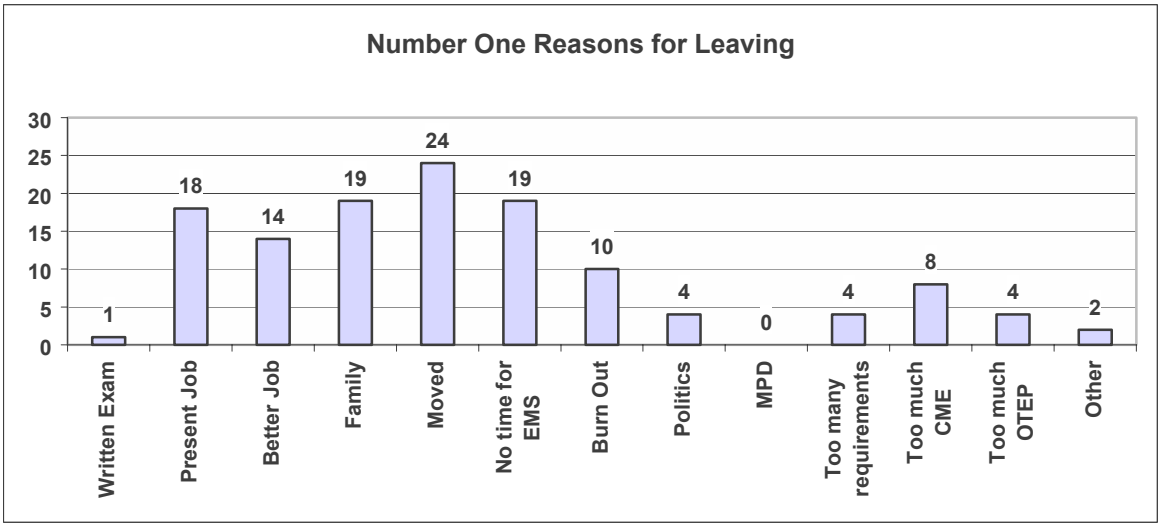
COUNTY	FR	EMT	IV	AW	IV/AW	ILS	ILS/AW	PM	2003 Totals	2003 % Career	2003 % Volunteer	2001 Totals	2001 % Career	2001 % Volunteer
Adams	1	56	0	0	0	1	1	0	**58**	**17**	**83**	**54**	**6**	**94**
Asotin	0	35	1	0	2	0	0	6	**44**	**23**	**77**	**35**	**34**	**66**
Ferry	1	42	0	0	0	3	1	0	**49**	**2**	**98**	**54**	**2**	**98**
Garfield	4	26	0	0	1	0	0	0	**31**	**0**	**100**	**21**	**0**	**100**
Lincoln	19	79	7	0	0	9	1	0	**115**	**3**	**97**	**120**	**1**	**99**
Pend Oreille	3	61	7	0	1	2	11	5	**90**	**26**	**74**	**104**	**14**	**86**
Spokane	115	1116	13	0	0	45	19	148	**1456**	**54**	**46**	**1379**	**53**	**47**
Stevens	23	141	4	0	0	38	0	2	**208**	**6**	**94**	**209**	**11**	**89**
Whitman	44	157	4	0	5	9	7	7	**233**	**15**	**85**	**262**	**14**	**86**
Totals	**210**	**1713**	**36**	**0**	**9**	**106**	**40**	**168**	**2282**	**16.2**	**83.8**	**2292**	**38**	**62**
Idaho*	0	22	21	0	1	0	0	18	**62**	**84**	**16**	**54**	**93**	**7**

Source: DOH, Licensing and Certification Section

*Idaho does not participate in training or other activities with the East Region and are therefore listed separately.

1. General Statement

Volunteer Base – Retention & Retainability: At this time 83.8% of all rural EMS providers in this region are volunteers. The information in the above Table comes from Licensing and Certification. The information in the Table indicates an increase in volunteers by almost 16% from 2001, as well as the fact that East Region has lost only 10 providers in the period between 2001 and 2003. Although some rural agencies have trouble with retention and retainability because of the vast volunteer base only a few of the very rural counties may have trouble filling an EMT class.



C. 1.b. PREHOSPITAL TRAINING RESOURCES

1. General Need Statement

Eight of the nine counties in the East Region are rural. Many of the prehospital agencies in these counties do not have funding for initial training of EMTs and/or FRs, or for CME training. The Regional Council provides 47% its contractual funds to rural prehospital training annually through its contract with the Inland Empire Training Council (Mobile Training Van). For the Regional Council to provide additional training to enhance skill knowledge, outside funding must be acquired. In 2002 the Regional Council spent $126,780 on prehospital provider training, $25,000 from grant funding, and was still not able to provide all the training providers need.

The additional funding sought for FY 04 was not allocated. Most local councils do not have funding to provide EMT or FR initial training in their counties, making the volunteer responsible for his/her own training expenses. Many agencies utilize the Prehospital Needs Grant Program through the DOH, EMS and Trauma Systems office to fund initial classes.

The new requirements for EMS/EMT instructors have brought new challenges for their certification. The most pressing challenge at this point seems to be the availability of the DOT instructor course or similar offering

It has become increasingly difficult for the Regional Council to provide an adequate amount of prehospital provider training without additional funding. There is discussion at the state level about changing EMS regions to those of public health. If that happens, the East Region will add Columbia County to its already geographically large region and expenses will increase. There has been no increase in funding for training in this region since 1992, 11 years ago. Costs tend to rise and the number of classes provided decrease. At some point in time, it may be necessary for the state agency providing training funds to EMS regions to look at the needs of the regions rather than providing an equal division of funds, especially since outside funding for EMS training is very limited.

2. Goal 1: Prehospital EMS/TC Training Should be Provided Regionwide

COMMUNITY BASED EDUCATION PROGRAM

Inland Empire EMS Training Council (Mobile Training Van–MTV)

The Inland Empire EMS Training Council (IETC), here after referred to as the Training Council, was established in the early 1990's and operates the Mobile Training Van (MTV) that provides training throughout the East Region. This program enjoys an outstanding reputation throughout the nine counties. Because training goes to the rural areas, EMS/TC providers are able to keep up with required OTEP/CME and are able to take advantage of other courses provided by the MTV. It is the desire of the Regional Council to continue providing OTEP/CME training to rural paid/volunteer EMS/TC providers in such a manner as to provide convenience and accessibility.

OTEP/CME: The main focus of the Mobile Training Van is to provide Community Based Continuing Medical Education through the regions Ongoing Training & Education Program (OTEP).

Rural BLS volunteer providers are the target audience. It is the intention for the Regional Council to include and promote ILS/ALS OTEP regionwide once approved and implemented by the DOH. It is also the intention of the Regional Council to add a Weapons of Mass Destruction (WMD) module to the current regional OTEP.

Mileage: The goal of community-based education is to reduce the number of miles that prehospital care providers travel in order to receive required OTEP/CME and thus decrease attrition. The Department of Health requires tracking of one-way miles traveled to education in order to evaluate the effectiveness of the program. The number of miles traveled by East Region providers dramatically decreased by 1999 to 3.5 miles. There was a slight increase in 2001 of .13 miles for a total one-way trip of 3.63 miles. Miles traveled through FY 03 to receive CME/OTEP training was 4.61 miles, an increase of nearly 1 mile over a period of 2 years.

An increase in mileage may appear again in FY 04 due to the 6 Infectious Disease interactive classes being piloted via teleconferencing. Teleconferencing is available at all regional hospitals, however some EMS providers will have to travel further in order to receive this training. One of the reasons for piloting teleconferencing for training is to see if it will reduce the cost of funding CME/OTEP provided through the MTV.

PHTLS: In response to the Department of Health requirement for trauma training, the Regional Council and Inland Empire Training Council have provided Prehospital Trauma Life Support (PHTLS) classes throughout the East Region for a number of years.

PHTLS is still a very viable training course for prehospital volunteer rural providers in East Region because of the intensity of the course study. PHTLS is a two-day 16-hour course offered to rural prehospital providers who find it difficult to maintain skills due to the response areas of their agency. PLTLS providers receive intense updates and a comprehensive class of trauma skills, application and the ability to work and network with other agencies in order to apply skill principles to the appropriate practice. Approximately 50-70 students can receive training at one time. PHTLS is the highest attended course offered by the Training Council to rural EMS providers.

Because of the cost of putting on a PHTLS course, the Training & Education Committee has considered the possibility of charging a $25 registration fee for PHTLS. No decision on the fee has been made at this time. When surveyed, volunteer agencies have indicated that funding is not available for them to pay the registration fee for their providers. In lieu of this information, the Regional Council has, and will continue, to apply for outside grant funding to help fund PHTLS.

Pediatric: The American Academy of Pediatrics has rolled out a new pediatric course designed specifically for pre-hospital providers (PEPP). This program has received excellent reviews and is an appropriate avenue to upgrade East Region pediatric education. Last year the director of the EMS Training Council received the credentials to coordinate this course and train instructors. In the last biennium the Regional Council was able to offer 6 BLS PEPP classes through funding acquired from the Washington Traffic Safety Commission's grant process.

Weapons Of Mass Destruction (WMD): Through outside funding the East Region was able to provide 8 Responder Awareness courses in the eight rural counties of the region and 3 Technician classes for ALS providers during 2003. The Regional Council had also planned to include WMD

classes in the 2003 EMS Conference, which was cancelled due to lack of registration.

The FY04-05 survey indicates that over the next 36 months providers would like to have additional training in: 1) 520 providers = Incident Command; 2) 1315 providers = Triage; 3) 814 providers = Bioterrorism; and 4) 996 providers = WMD. There are various organizations that may be able to provide funding sources for this type of training during the next biennium.

Instructor Support: In addition to providing education for the pre-hospital EMS/TC provider, the Training Council offers instructor education to increase the quality and availability of pre-hospital educators. In order to be cost effective, instructor education is offered jointly to the East/North Central Region instructors.

C.1.c. PRIORITIZING AND CONDUCTING PREHOSPITAL TRAINING

Need for Training

CME and OTEP are provided annually and funded through the contractual agreement between the Regional Council and the DOH. The Training & Education Committee has identified additional training needs through a training survey for FY 04 and FY 05. Some examples of training requests are:

Prioritization List & Out of Pocket Costs (Current Value)

1. The major priority for training region wide is CME and OTEP. In the past, the Regional Council has committed $101,780 annually to ensure this training is accomplished. (Biennium costs = $203,560)
2. Intermediate Life Support – Projected cost of 2 classes in 2002 is $15,000. (Biennium cost = $30,000)
3. Paramedic Training – Projected costs for four scholarships in 2002 is $8,800. (Biennium costs = $17,600)
4. Pediatric Education for Prehospital Providers (PEPP) – Projected costs for 6 BLS PEPP classes during 2002 is $6,000. Projected cost for ALS PEPP is $2,000 each class.
5. PHTLS – Projected costs for 2 Provider classes and 1 refresher class is $12,000 (biennium costs = $24,000)
6. 12 Initial BLS Provider Courses – Projected costs for 2001 = $38,400 (biennium costs $76,800)
7. Weapons of Mass Destruction - $16,000 (2003 only)

Process For Prioritizing And Securing Training

The Training & Education Committee prioritizes the training needs of the region in the spring of each fiscal year. The committee uses the results of the needs assessment to determine what the training needs are. If there are additional needs, and funding is not available through a contractual agreement, outside funding is sought to cover costs.

The Regional Council contracts with the Inland Empire Training Council to provide CME, OTEP and PHTLS throughout the fiscal year. If funding is available, the Regional Council may

also contract with the Training Council to provide special skills classes such as ILS training, PEPP and/or Weapons of Mass Destruction.

The County EMS/TC councils sponsor initial FR and EMT training as well as some special skills classes. Students pay a registration fee for the class and if the county has funding available, instructors receive a stipend. In most counties instructors are not reimbursed for teaching a class.

C.1.d. ADDITIONAL PUBLIC SAFETY PERSONNEL ROLE AND AVAILABILITY

Public safety personnel attend the EMT-Basic courses offered in the East Region on a routine basis. EMS and trauma care providers work hand in hand with law enforcement, search and rescue and also utilize military resources as it is appropriate. Other entities involved in public safety as it relates to the EMS and trauma system are: Washington State Patrol, Sheriff's Departments, Fairchild AFB, Air National Guard, Emergency Management, Public Health, American Red Cross, Rural Health, Civil Air Patrol, and other military squadrons at Fairchild AFB, the Army Guard & Reserves and the Reserve Unit out of Camp Murray.

With the implementation of Homeland Security and the funding and directives provided by HRSA and CDC, the East Region has and will continue to develop new partners for providing training. Inland Northwest Health Services (INHS) continues to broaden its bases for using TeleHealth in this region. Currently INHS and Spokane County EMS have developed a TeleHealth (teleconferencing) course called *EMS Live At Night* with prehospital providers in mind. A very successful *EMS Life At Night* was focused on Meth Labs. The Regional Council has plans to offer its council and committee meetings (at least some of them) over teleconferencing. Teleconferencing works very well for both hospital and prehospital providers.

- Six Infectious Disease interactive courses will be offered via teleconferencing during FY 03 on a trial basis.

Public Health is providing specific Smallpox training within the region, however most of it is currently directed to hospitals. They have made additional training available through the use of videos mainly focused on WMD, Risk Management, Infectious Disease, etc.

1. Need

Some of the difficulties encountered include:

- OTEP and community-based training have helped significantly, but travel and the time involved away from business and family remain economically and socially expensive for the volunteer provider. With these factors, there remains a high level of burnout among pre-hospital personnel and quality of care is potentially threatened.

- Spokane Community College is currently the only college in the East Region offering an EMT course curriculum. The cost of EMT and FR courses is borne by the sponsoring organization or in many rural areas, by the individual volunteer. Individual cost per class is $650.

- There is a lack of qualified instructors. This and other factors add to the difficulty in increasing the number of trained personnel at all levels, as well as maintaining their certifications.

A. Many ALS courses recommend that instructors be physicians, specifically surgeons, who are not readily available in urban areas, let alone rural areas.

B. There is a lack of support funding for instructors, particularly in rural areas.

C. Geographic configuration of the region with long distances and hazardous winter travel for instructors and students is a major stumbling block.

As long as our pre-hospital providers are made up of 83.8% volunteers, it will be a constant struggle to have people step forward, receive training, stay around for three to six years, and not get burned out. The East Region remains strongly committed to overcoming the difficulties of recruiting, training, maintaining, and retaining rural EMS volunteers.

2. Goal 1: Prehospital EMS/TC training is provided regionwide.

Objective 1: ***A plan will be developed to implement ILS/ALS OTEP regionwide by 6/30/04.***

Strategy 1: The Training & Education Committee will work with its membership to develop tentative plans for providing education if the state approves the new ILS/ALS CME/OTEP program.

Projected Cost: To be Determined

Objective 2: ***The Training & Education Committee will work to maximize the number of classes that can be offered in the rural areas of the region throughout the biennium.***

Strategy 1: Plans will be developed for providing trauma training.

Strategy 2: The number of classes that are to be provided will be governed by contract for each fiscal year.

Projected Cost: See Prioritization List & Out of Pocket Costs

Objective 3: ***Maintain* or i*ncrease the number of EMS/EMT instructors within the rural areas of the region by 6/30/04.***

Strategy 1: The Training & Education Committee will develop plans for providing the DOT instructor course.

Strategy 2: Any classes that can be provided will be governed by contract for each fiscal year.

Project Cost: To be Determined

Objective 4: ***Pursue the development of ILS and paramedic initial training programs regionwide throughout the biennium.***

Strategy 1: Pursue outside funding to support ILS and paramedic training regionwide.

Projected Cost: $15,000 for 2 ILS classes

Objective 5: ***Continue to Improve the Mobile Training Van Service***

Strategy 1: Every two years the region, through the Training & Education Committee, distributes a training survey to all prehospital agencies asking what types of instruction they will need over the next three years. This survey also asked the provider to give feedback on the mobile training van, which is then reviewed by the Training & Education Committee. After committee review recommendations are forwarded to the Inland Empire Training Council for consideration.

Project Cost: $1000

Objective 6: ***Encourage local councils to financially support initial training for certification of EMT/FR to offset attrition rates and increase the number of personnel certified.***

Strategy1: A database is kept of all courses approved by the DOH but not funded by the region. This provides important information to the Training & Education Committee on how much initial training is being done during the fiscal year.

Strategy 2: Advise local EMS/TC councils to encourage prehospital agencies to apply for training funds through the Prehospital Needs Grant program.

Project Cost: $100

Objective 7: ***Ensure that education and training programs reflect recent and upcoming regulatory and curriculum changes.***

Strategy: The Inland Empire Training Council, contracted by the EREMSTC, ensures that all regulatory and curriculum changes are current and appropriate. A representative of the IETC serves on the Training & Education Committee to ensure good communications between the rural providers and the committee.

Project Cost: Included in contractual agreement between East Region and Inland Empire Training Council. No additional cost.

Objective 8: ***Support existing programs and conduct additional training programs to expand BLS capabilities throughout the region.***

Strategy 1: The Training & Education Committee will consider the possibility of incorporating additional pediatric training in the regional OTEP by 12/31/03.

Strategy 2: A WMD module will be included in the regional OTEP by 12/31/03.

Strategy 3: The Training & Education Committee will seek funding to provide WMD training to rural providers through various organizations sponsoring this type of activity.

Project Costs – See Prioritization List & Out of Pocket Costs

Annual Cost = $183,980

Biennium Cost = $367,960

IV.D. VERIFIED AID AND AMBULANCE SERVICES

1.a. GEO-POLITICAL PREHOSPITAL RESPONSE AREAS

Verified aid and ambulance services in the East Region may represent a fire department, hospital district or EMS organization.

Eight of the nine counties in the region have completed their Need and Distribution of Services document from which the information in Table 2 below was taken. Each document represents numerous hours of discussion, planning and development by the county EMS/TC councils, its respective verified agencies and the regional Prehospital & Transportation Committee. Although the Adams County document is in "draft" form, the information in it is correct and has been included in the Table 2.
Adams County has recently reactivated its county EMS/TC council. The Regional Council, through its Prehospital & Transportation Committee will ensure the completion of the Adams County document by working with its membership.

Prehospital Response Areas are specifically identified in the County Narrative on Need and Distribution of Services Addendum A. A Response Area Map is included with each county narrative.

Prehospital Planning Areas (Urban, Suburban, Rural, And Wilderness)

Planning areas are identified in the Needs and Distribution (b) of this section. Specific county planning area information is included in the County Narratives on Need and Distribution of Services. The East Region's 15,536 square mile area is mostly rural. Some of the areas, Lincoln, Ferry, Stevens, Pend Oreille and even Spokane County have some areas of wilderness. Spokane County is mainly urban, although there are some rural and wilderness areas in the county as well.

Table 1 (below) identifies specific attributes of each of the nine counties within the region. The information is taken from the most current Data Book distributed by the Office of Financial Management. It shows the size, population and population density per square mile as well as incorporated and unincorporated areas. Garfield County is the smallest county in the region by both land area by square mile and total population base.

County	Land Area Square Mile	Total Population	Population Density Square Mile	Proportion Incorporated	Proportion Unincorporated
Adams	1925	15900	8.3	8061	7839
Asotin	635.9	20000	31.5	8055	11995
Ferry	2204	7300	3.3	1040	6260
Garfield	710.5	2400	3.4	1445	995
Lincoln	2311.2	10000	4.3	5749	4251
Pend Oreille	1400.5	11100	7.9	3080	8020
Spokane	1763.8	414500	235	212459	202041
Stevens	2478.3	38000	15.3	9446	28554
Whitman	2159.4	41900	19.4	35162	6738
Total	**15,588.4**	**561,100**		**28,4497**	**27,6693**

Table 2 (below) further identifies the Geo-political prehospital response areas by county, current distribution of trauma verified services, needs or changes in service, and gives a total picture of the EMS & Trauma System within the region.

Geo-political prehospital response area & category	Current Distribution of Trauma Verified Services	Verified Services Response Areas for Major Trauma	Needs: Unmet services needs or changes in service needs for Trauma Verified Services
Adams County (Rural)	Othello Ambulance BLS service Adams Co. PHD #2 – BLS ambulance service provided in Washtucna, Lind and Ritzville	See Response Area Maps and description available in Addendum	None identified
Asotin County (Rural)	Clarkston Fire Dept. – ILS first response service in Asotin County Lewiston Fire Dept – ALS transport service in Asotin County	See Response Area Maps and description available in Addendum	None Identified
Ferry County (Rural & Wilderness)	Ferry Co. EMS District #1 BLS transport service in Republic Area N. Ferry Co. Ambulance BLS service in Curlew & Northern Ferry County area	See Response Area Maps and description available in Addendum	None Identified
Garfield County (Rural)	Garfield Co. FD #1 BLS ambulance service	See Response Area Maps and description available in Addendum	None Identified
Lincoln County (Rural & Wilderness)	Creston Ambulance BLS Service Reardan – Lincoln Co. FD #4 BLS First Response Davenport – Lincoln Hospital District #3 BLS Ambulance Harrington – Lincoln Co. FD #6 BLS Ambulance Odessa – Lincoln Hospital District #1 – BLS Ambulance Sprague – Lincoln Co. FD #3 – BLS Ambulance	See Response Area Maps and description available in Addendum	None Identified

	Wilbur – Lincoln Co. FD #7 BLS Ambulance		
Pend Oreille County (Rural and Wilderness)	Pend Oreille FD #2 BLS Transport Pend Oreille FD #3 BLS Aid Pend Oreille FD #4 BLS Aid Pend Oreille FD #5 BLS Aid Pend Oreille FD #6 BLS Aid Pend Oreille FD #7 BLS Aid Pend Oreille FD #8 BLS Aid Cusick Fire Department BLS Aid Newport Ambulance BLS Transport	See Response Area Maps and description available in Addendum	None Identified
Spokane County (Urban, suburban, rural & wilderness)	Airway Heights FD BLS Aid Airport Fire Dept. BLS Aid Cheney FD BLS Aid Millwood FD BLS Aid Medical Lake FD BLS Aid Spokane FD #3 BLS Aid Spokane FD #4 BLS Aid Spokane FD #5 BLS Aid Spokane FD #8 BLS Aid	See Response Area Maps and description available in Addendum	

	Spokane FD #9 ALS Aid Spokane FD #10 BLS Aid Spokane FD #11 BLS Aid Spokane FD #12 BLS Aid Spokane, FD #13 BLS Aid Spokane Co. FD #2 BLS Ambulance Spokane City Fire ALS Aid Spokane Fire District #1 ALS Aid American Medical Response ALS Ambulance Deer Park Ambulance ALS Ambulance Northwest Med Star Air Transport for all counties of the region.		
Stevens County (Rural & Wilderness)	Stevens Co. FD #1 BLS First Response Marble First Response & Rescue BLS First Response Stevens Co. FD #8 BLS First Response Rice First Response (Stevens County Sheriff's Ambulance) BLS First Response Northwest Alloys First Response (Stevens Co. Sheriff's Ambulance)	See Response Area Maps and description available in Addendum	An area in northwest Stevens Co. of approx. 100 sq. miles, between Barney's Orient FD #8 and response area of Marble First Response and Rescue, is currently without a first response agency. Ambulance transport is dispatched from Colville or Kettle Falls with a response time to the scene of 15-40 minutes. Deep Lake/Aladdin area, the northeast corner of Stevens

	BLS First Response National Park Service BLS First Response Stevens Co. Sheriff's Ambulance BLS Ambulance Transport Chewelah Rural Ambulance BLS Transport Spokane Tribal Ambulance BLS Transport Deer Park Ambulance ALS Transport Suncrest Ambulance BLS Transport 40 Degree North Ski Patrol – on site only		County, an area of approx. 80 sq. miles, is currently without a first response agency. This area is very active with outdoor activities including hunting, fishing, boating and camping. Marble First Response and Rescue is covering this area, but the response time would be greatly reduced with an agency in the immediate area. Pend Oreille Lakes area, east of Colville fifteen to twenty-eight miles, an area of approx. 65 sq. miles, is currently without a first response agency. This area is also very active with outdoor activities including hunting, fishing, boating, hiking and camping. Ambulance transport is dispatched from Colville with a response time to the scene of 20-35 minutes. Hunters/Fort Spokane area, the southwest corner of Stevens Co., an area of approx 115 sq. miles, is currently without a first response agency. Ambulance transport is dispatched from Chewelah with a response time to the scene of 25-45 minutes, or Spokane Tribal Ambulance with a response time of 15-25 minutes. Waitts Lake/Deer Creek area, southwest of Chewelah, an area of approx. 70 sq. miles, is currently without a first

			response agency. Ambulance transport is dispatched from Chewelah with a response time to the scene of 12-25 minutes. Northwest Stevens Co., south of Laurier and east of Orient including Pierre Lake area, lies 30-40 minutes travel time from the nearest transport service in Colville. Need – Additional ambulance service based in the northern end of Fire District #8. General area of Loon Lake, Springdale and Deer Lake in southern Stevens Co. lies 15-20 minutes travel time from the nearest transport service in Chewelah or Deer Park. Need ambulance service in Loon Lake or Springdale area. General area of Rice, Gifford and Hunters in southwestern Stevens Co. lies 25-40 minutes from the nearest transport service (either Colville or Chewelah). Need – additional transport service based in Hunters or Rice area.
Whitman County (Rural & Wilderness)	Town of Albion Fire & EMS BLS Ambulance Colfax Fire & Rescue BLS Ambulance City of Colfax BLS Aid Whitman Co. FD #14 Colton/Uniontown VLS Aid	See Response Area Maps and description available in Addendum	None Identified

	Whitman Co. FD #11 Diamond BLS Aid Endicott Emergency Medical Response BLS Aid Whitman Co. Hospital District #2 Garfield Ambulance BLS Ambulance in Garfield BLS Aid in Farmington Whitman Co. FPD #5 Lamont BLS Aid LaCrosse Rescue BLS Aid Malden Vol. Fire & EMS BLS Aid Oakesdale Fire Dept. BLS Aid Palouse EMS BLS Aid Pullman Fire Services ALS Ambulance Rosalia Vol. Fire Dept. BLS Ambulance 1 Aid at Thornton Whitman Co. FD #12 BLS Aid Whitman Co. FD #11 BLS Aid St. John Volunteer FD BLS Aid Tekoa Community Ambulance BLS Ambulance WSU Fire Dept. 2 BLS Ambulance 1 BLS Aid		

1.b. NEED AND DISTRIBUTION OF SERVICES

WAC 246-976-960 (1)(b)(i) states:

(1) In addition to meeting the requirements of chapter 70.168 RCW and elsewhere in this chapter, regional EMS/TC councils must:

(b) Develop and submit to the department regional EMS/TC plans to:

(i) Identify the need for and recommend distribution and level of care (basic, intermediate or advanced life support) for verified aid and ambulance services for each response area. The recommendations will be based on criteria established by the department relating to agency response times, geography, topography, and population density;

Regional Process for Determining Need and Distribution of Services: Guidelines for developing the Need and Distribution of Services are provided by the DOH. These guidelines are distributed to each agency and county EMS/TC council. The need for the development of these documents was made a deliverable in agreements between the county and regional EMS/TC councils. A review schedule is developed and provided to each county. County councils work with their agencies to ensure accuracy in the document. The documents are then presented to the Prehospital and Transportation Committee for review and recommendation to the Regional Council, which then adopts the document and submits it to the DOH for review and approval. The council then used the information in these narrative documents to produce Table 2 section 1.a.

Changes to Need and Distribution of Service Documents: There was a small change in the Spokane County Need and Distribution of Services language located under "Proposed System Changes" in the County Narrative on Need and Distribution of Services addendum. The change did not effect the recommendation of verified aid and ambulance services within the county.

Each county is asked to review and revise their narratives at least biennially through the agreement between the regional and county councils. Any changes to these documents are again reviewed by the Prehospital & Transportation Committee with a recommendation to be presented to the Regional Council for adoption.

2. Need:

3. Goal 1: Need and Distribution of Services Are Complete

Objective 1: ***All nine counties in the region will have completed their Need and Distribution of Services documents and have had them approved by the Department by 6/30/04.***

Strategy 1: Representatives from Adams County EMS/TC Council will be invited to participate in the Prehospital and Transportation Committee.

Strategy 2: The Regional Council President and/or Prehospital & Transportation Committee Chair will attend Adams County EMS/TC Council meetings to provide guidance in the development and completion of the Need and Distribution of Services document.

Strategy 3. Each county EMS/TC council will be asked to review for revisions its Need and Distribution of Services document by June 30, 2004.

Other Needs Not Related to Distribution of Service: In order for prehospital providers to continue to provide excellent patient care, licensed and verified services need the necessary equipment to enhance their services. In a recent survey nearly all rural volunteer prehospital licensed and verified agencies identified needs for: 1) trauma equipment; 2) medical equipment; 3) communications equipment such as but not limited to radios, repeaters and base stations as well as pagers, cell phones and GPS devices; 4) training equipment; and 5) extrication equipment and extrication training;.

GPS Tracking Devices: Historically, EMS agencies have relied on local names of geographical landmarks to identify the location of an injured patient. Unfortunately, because of the size of Northwest MedStar's response area, Communications Specialists and/or pilots may not be familiar with these local names. Other means of identify location include Section, Township, Range; highway and road intersections and mileage from a specific town. While these methods of scene location are effective, they often involve multiple questions between our Communication Specialists and the EMS agencies and require a review of a commonly agreed map. These steps increase the response time and, in several incidents, resulted in the dispatch of an air medical helicopter to the wrong location. The use of Global Positioning Satellite (GPS) will allow direct flight to the scene, decreasing scene response time.

Some agencies in the region have purchased GPS devices, however Northwest MedStar documented a need for nearly 100 devices in this region alone.

3. Goal 2: Rural EMS and trauma care providers have the equipment and training necessary to provide excellent patient care as verified services..

Objective 1*: **Survey all licensed and verified aid and ambulance services for needs on a biennial basis.***

Strategy 1: Encourage all rural prehospital agencies with needs (not limited to those identified above) to apply for funding through the Prehospital Needs Grant program.

Strategy 2: Ask county EMS/TC councils to encourage agency participation in the Prehospital Needs Grant program.

Table B

VERIFICATION

East Region

Date: December 2002

B. Min/Max Numbers for Trauma-Verified Prehospital Services

Instructions:

a. List the current DOH-approved number of prehospital verified services within the region by county.
b. Using the information identified in the narrative above regarding the need and distribution process for each county, specify the regionally- recommended minimum/maximum number of prehospital verified services within the region, by county.
c. List the current number of services verified at each level, as identified in the need and distribution section.
d. Submit a completed Table B for each county

NOTE*:* Only a number or a zero may be entered as a recommendation in each of the blanks below, and each blank must contain either a number or a zero.)

Services	**STATE APPROVED**		**CURRENT STATUS**	**REGION PROPOSED (Indicate changes with an *)**	
ADAMS County	**MIN**	**MAX**		**MIN**	**MAX**
Aid - BLS	0	0	0	0	0
Aid - ILS	0	0	0	0	0
Aid - ALS	0	0	0	0	0
Amb-BLS	2	2	2	2	2
Amb - ILS	0	0	0	0	0
Amb - ALS	0	0	0	0	0

Services	**STATE APPROVED**		**CURRENT STATUS**	**REGION PROPOSED (Indicate changes with an *)**	
ASOTIN County	**MIN**	**MAX**		**MIN**	**MAX**
Aid - BLS	0	0	0	0	0
Aid - ILS	1	1	1	1	1
Aid - ALS	0	0	0	0	0
Amb-BLS	0	0	0	0	0
Amb - ILS	0	0	0	0	0
Amb – ALS	1	1	1 **Lewiston, ID**	1	1

Services	STATE APPROVED		CURRENT STATUS	REGION PROPOSED (Indicate changes with an *)	
FERRY County	MIN	MAX		MIN	MAX
Aid - BLS	0	0	0	0	0
Aid - ILS	0	0	0	0	0
Aid - ALS	0	0	0	0	0
Amb-BLS	2	2	2	2	2
Amb - ILS	0	0	0	0	0
Amb - ALS	0	0	0	0	0

Services	STATE APPROVED		CURRENT STATUS	REGION PROPOSED (Indicate changes with an *)	
GARFIELD County	MIN	MAX		MIN	MAX
Aid - BLS	0	0	0	0	0
Aid - ILS	0	0	0	0	0
Aid - ALS	0	0	0	0	0
Amb-BLS	1	1	1	1	1
Amb - ILS	0	0	0	0	0
Amb - ALS	0	0	0	0	0

Services	STATE APPROVED		CURRENT STATUS	REGION PROPOSED (Indicate changes with an *)	
LINCOLN County	MIN	MAX		MIN	MAX
Aid - BLS	2	2	2	2	2
Aid - ILS	0	0	0	0	0
Aid - ALS	0	0	0	0	0
Amb-BLS	6	6	6	6	6
Amb - ILS	0	0	0	0	0
Amb - ALS	0	0	0	0	0

Services	STATE APPROVED		CURRENT STATUS	REGION PROPOSED (Indicate changes with an *)	
PEND OREILLE County	MIN	MAX		MIN	MAX
Aid - BLS	6	7	7	6	7
Aid - ILS	0	0	0	0	0
Aid - ALS	0	0	0	0	0
Amb-BLS	2	3	3	2	3
Amb - ILS	0	0	0	0	0
Amb - ALS	0	0	0	0	0

Services	STATE APPROVED		CURRENT STATUS	REGION PROPOSED (Indicate changes with an *)	
SPOKANE County	MIN	MAX		MIN	MAX
Aid - BLS	13	13	13	13	13
Aid - ILS	0	0	0	0	0
Aid - ALS	3	3	3	3	3
Amb-BLS	1	1	1	1	1
Amb - ILS	0	0	0	0	0
Amb - ALS	2	2	2	2	2

Services	STATE APPROVED		CURRENT STATUS	REGION PROPOSED (Indicate changes with an *)	
STEVENS County	MIN	MAX		MIN	MAX
Aid - BLS	5	8	3	5	8
Aid - ILS	0	0	0	0	0
Aid - ALS	0	0	0	0	0
Amb-BLS	3	4	3	3	4
Amb - ILS	0	0	0	0	0
Amb - ALS	1	1	0	1	2

Services	STATE APPROVED		CURRENT STATUS	REGION PROPOSED (Indicate changes with an *)	
WHITMAN County	**MIN**	**MAX**		**MIN**	**MAX**
Aid - BLS	10	13	11	10	13
Aid - ILS	0	0	0	0	0
Aid - ALS	0	0	0	0	0
Amb-BLS	8	13	6	8	13
Amb - ILS	1	5	0	1	5
Amb - ALS	1	2	1	1	2

IV.E. PATIENT CARE PROCEDURES (PCPS) AND COUNTY OPERATING PROCEDURES (COPS

1. Current Status: All Regional Patient Care Procedure (PCPs) and County Operating Procedures (COPs) have been approved by the DOH and implemented regionwide.

Regional Patient Care Procedures (See Attachment 1)

Patient Care Procedures as defined in WAC are written operating guidelines adopted by the regional EMS/TC council, in consultation with local EMS/TC councils, emergency communications centers and the MPDs, in accordance with statewide minimum standards. The Patient Care Procedures identify the level of medical care personnel to be dispatched to an emergency scene, procedures for triage of patients, the level of trauma care facility to first receive the patient, and the name and location of other trauma care facilities to receive the patient should an interfacility transfer be necessary. Procedures on interfacility transfer of patients shall be consistent with the transfer procedures in chapter 70.170 RCW.

In the East Region, the established policy allows for newly developed and/or revised Regional Patient Care Procedures to be mailed to all local EMS/TC councils, Medical Program Directors, and communications centers, as well as Regional Council members and alternates. Recommended changes are submitted to the Regional office, and the process begins all over again until the Regional Council adopts a Regional Patient Care Procedure. At that time, the document is forwarded to the DOH for review and approval.

Regional Patient Care Procedures	Description
PCP #1	Dispatch of Medical Personnel
PCP #2	Response Times
PCP #3	Triage & Transport
PCP #3A	Triage & Transport of Pediatric Patients
PCP #3B	Triage & Transport of Medical and Non-Trauma Patients
PCP #4	Interfacility Transfer
PCP #5	Medical Group Supervisor at the Scene
PCP #6	EMS/Medical Control Communications
PCP #7	Helicopter Response (1996 version is approved)

County Operating Procedures

County Operating Procedures (COPs) are developed in much the same way as Regional Patient Care Procedures. They are developed at the county level and should include the same provider involvement as listed in WAC 246-976-960 (1) (g) as for regional Patient Care Procedure development. County EMS/TC councils, in conjunction with Medical Program Directors and communications centers, approve the procedure and forward it to the Regional Council, where the Prehospital & Transportation Committee reviews the document. If the Prehospital & Transportation Committee approves the document submitted, it is then sent forward to the Regional Council for adoption, or returned to the county council for further revisions. Once adopted by the Regional

Council, the COPs are then forwarded to the Department of Health for review and approval. Once the Department has approved the document, it becomes an official part of that particular Regional PCP and is included in the Regional PCP Manual.

The Regional Council has charged each of its nine county EMS/TC councils to develop, review, revise, and once adopted by the Regional Council and approved by the Department of Health, implement County Operating Procedures. These procedures outline how the county will implement regional Patient Care Procedures.

2. Need: County COPs are not being maintained and improved as often as necessary.

3. Goal 1: County Operating Procedures (COPs) within the region are up to date.

Objective 1: Ensure that all County Operating Procedures are in accordance with the currently approved Regional PCPs.

Strategy#1: The Prehospital & Transportation Committee will monitor county COPs and make recommendations to update COPs as necessary.

Projected Costs: To be determined by number of county's with COPs that need to be updated.

Critical Barriers: None Identified.

IV. F. MULTI COUNTY OR COUNTY/INTER-REGIONAL PREHOSPITAL CARE

Mutual Aid Agreements

At this time the written county mutual aid agreements are current and in place. The Council asks its county councils to update these agreements biennially in order to ensure hat they are current. Some counties have agreements with other counties, some with other regions, and in the case of Ferry County, they have an agreement that crosses the Canadian border. A list of these agreements is available at the Regional office upon request.

Medical Program Directors ensure that EMS providers know which counties patient care protocols, COPs and or Regional Patient Care Procedures are being used when providing patient care in another area.

1. Need

The region needs to have county EMS/TC councils assess their mutual aid agreements and patient care protocols to determine if they are accurate and provide patient care across various boundaries. There are also areas that border the North Central and South Central Regions, as well as Idaho and Canada that may not cover crossing boundaries to provide for patient care.

2. Goal: Mutual Aid Agreements are in place for multi-county and/or county/inter-regional Prehospital Care

Objective 1: ***Documents are in place to provide guidance for EMS responders providing patient care crossing county and regional boundaries by 6/30/05.***

Strategy 1: Include language in the agreements between county and regional EMS/TC councils that provides a deliverable for assessing current mutual aid agreements to determine whether or not they provide for multi-county and or county/inter-regional patient care by June 2004.

Strategy 2: Work with county EMS/TC councils in the preparation of documents that provide for multi-county patient care.

Strategy 3: Work with county EMS/TC councils to determine if appropriate documents are in place for those areas that cross state and federal boundaries.

Strategy 4: Collaborate with the North Central and South Central Regional Administrators to determine if the appropriate patient care documents are in place for inter-regional patient care.

Projected Cost: $5,000

V. DESIGNATED TRAUMA CARE SERVICES

There are nineteen designated trauma services within the East Region, including one joint designation. Fourteen of the designated trauma centers in the East Region are rural and have very different needs than the urban trauma centers. Trauma services are an integral part of the EMS and Trauma Care System. The Regional Council provides recommendations for minimum and maximum numbers, levels and locations of trauma designations annually to the DOH based on recommendations from the hospitals themselves. Recommendations are based on the needs and capabilities of a hospitals particular community.

Critical Access

Several of the rural trauma designated facilities in the region are also Critical Access Hospitals. The Critical Access Hospital (CAH) Program was created by the 1997 federal Balanced Budget Act as a safety net device, to assure Medicare beneficiaries access to health care services in rural areas. It was designed to allow more flexible staffing options relative to community need, simplify billing methods and create incentives to develop local integrated health delivery systems, including acute, primary, emergency and long-term care. In Washington State, the Critical Access Hospital program is administered by the Department of Health through the Office of Community and Rural Health (OCRH) and the Office of Facility and Services Licensing (FSL) Office of Survey, in close collaboration with the Washington State Hospital Association.

Nine of the twenty-six Critical Access facilities in the state are located in the East Region. Those hospitals are: Garfield Co. Memorial, Lincoln, Deer Park, Odessa, St. Joseph's in Chewelah, Newport, East Adams, and Othello. Whitman Hospital in Colfax is currently involved in the application process.

Hospital Disaster Preparedness

East Region designated health care facilities contracted with the Department of Health (DOH), Bioterrorism Preparedness Team in FY 03 to participate in individual Bioterrorism hospital assessments and to develop a Regional Bioterrorism (BT) Hospital Plan. For the purposes of developing the BT Hospital Plan, the region was expanded to include Columbia County, making it again the largest geographical region in the state. It is called Region 9.

The plan was developed with input from all 22 hospitals (including Shiners Children's Hospital, Eastern State Hospital, and the VA Hospital). The East Region EMS/TC Council recently merged its Health Care Facilities and Hospital Planning Committees into one committee called Hospital Planning.

1. Need Statement

Many of the rural health care providers must travel outside of their communities to receive trauma education. The geographical configuration of the region, with long distances and hazardous winter travel for instructors and students is also a problem.

The Bioterrorism Preparedness project currently underway in Washington State has given new meaning to the term " duplication of services". Spokane County has a Disaster Preparedness Committee that functions very similarly to that of the East Region Hospital Planning Committee. The council has been approached about merging the two committees into one Hospital Planning Committee.

2. Goals

Goal 1: All Designated Facilities Will Remain Designated.

Objective 1: Ensure that all training needs are met for acute care trauma.

Strategy 1: Training resources will be provided to trauma care providers in the region as identified in the trauma designation contract between hospitals and the DOH.

Projected Costs: To be determined by the Level II trauma designated facility providing the acute care training.

Goal 2: A unified Hospital Planning Committee is responsible for trauma center and hospital disaster preparedness planning.

Objective 1: Duplication of services relative to hospital disaster preparedness planning will be eliminated by December 2004.

Strategy 1: A representative of both committees will approach the Spokane County Disaster Committee to merge its resources with the East Region's (Region 9) Hospital Planning Committee.

Projected Cost: None

3. Designated General, Pediatric And Rehabilitation Trauma Facilities

A. The highest level of trauma designation in the East Region is in Spokane County with the joint level II designation of Deaconess and Sacred Heart Medical Centers. There are four level III trauma designations in the region located in Spokane (2), Pullman and Lewiston, Idaho. The level IV and V trauma centers are located in the rural areas of the region. There is one level I adult and pediatric trauma designated rehabilitation center located in Spokane.

There are no recommended changes to the minimum/maximum recommendations for general, pediatric or rehabilitation trauma services.

Current Trauma Designated Services

Spokane Joint Trauma Services (Deaconess Medical Center & Sacred Heart Medical Center)	Spokane	Levels II adult and II-Pediatric
St Joseph's Regional Medical Center	Lewiston, Idaho	Level II adult and III-Pediatric
Holy Family Hospital	Spokane	Level III adult
Pullman Memorial Hospital	Pullman	Level III adult
Valley Hospital & Medical Center	Spokane	Level III adult
Deer Park Health Center & Hospital	Deer Park	Level IV adult
Lincoln Hospital	Davenport	Level IV adult
Mount Carmel Hospital	Colville	Level IV adult
Newport Community Hospital	Newport	Level IV adult
St Joseph's Hospital of Chewelah	Chewelah	Level IV adult
Tri-State Memorial Hospital	Clarkston	Level IV adult
East Adams Rural Hospital	Ritzville	Level V adult
Ferry County Memorial Hospital	Republic	Level V adult
Garfield County Hospital District	Pomeroy	Level V adult
Odessa Memorial Hospital	Odessa	Level V adult
Othello Community Hospital	Othello	Level V adult
Whitman Hospital and Medical Ctr.	Colfax	Level V adult
St Luke's Rehabilitation Institute	Spokane	Level I adult/pediatric

EAST REGION

TABLE C

FY 04/05 Regional Plan
Min/Max Numbers for Acute Trauma Services

NO CHANGES TO THE MIN/MAX NUMBERS AT THIS WRITING

LEVEL	STATE APPROVED		CURRENT STATUS	REGION PROPOSED (Indicate changes with an *)	
	MIN	MAX		MIN	MAX
II	1	2	2	1	2
III	3	4	3	3	4
IV	8	10	6	8	10
V	3	6	6	3	6
IIP	1	2	1	1	2
IIIP	1	2	1	1	2

Min/Max Numbers for Rehabilitation Trauma Services

LEVEL	STATE APPROVED		CURRENT STATUS	REGION PROPOSED (Indicate changes with an *)	
	MIN	MAX		MIN	MAX
I	1	1	1	1	1
II	0	0	0	0	0
III+	0	0	0	0	0

VI. DATA COLLECTION AND SUBMISSION

A. Data

The East Region EMS/TC Council actively supported and encouraged its prehospital and hospital providers to submit data to the state registry beginning in 1996. The process used was based on county and regional data collection sites run by volunteers. Prehospital data was submitted to the county data collection site, which in turn submitted the data to the regional collection site. The region then forwarded the data to the state registry. Until July 1, 2001 the East Region was the only EMS region in the State of Washington to effectively collect medical and trauma prehospital data and submit it to the state registry.

Based on recent review of statute and rule DOH determined that prehospital agencies are not required to submit trauma data. As a result prehospital agencies are being asked to submit run sheets for trauma patients to the receiving Trauma Service. The hospital records the data and submits it to the DOH. First responders stopped collecting data altogether. Much of the prehospital patient data is missing**.** Currently the Regional Council has no role in the collection of prehospital data.

Need Statement

There is a need for the collection of prehospital trauma data in all counties of the region.

Goals, Objectives and Strategies

Goal 1: Collect Trauma Data

Objective 1: Develop a process for submission of prehospital trauma data to the state data registry by June 2005.

Strategy 1. Regional representatives will attend the Data Summit on September 18 & 19, 2003 in Wenatchee.

Strategy 2. Partner with county EMS/TC councils to plan, develop and implement a process for the collection of prehospital trauma data.

Strategy 3. Partner with Inland Northwest Health Services (INHS) to research the expansion of the current connectivity infrastructure to include submitting trauma data to the DOH.

Objective 2. Verified prehospital agencies are submitting trauma data to the receiving hospital.

Strategy 1: The Information Technology Committee will develop a region-wide survey on the types of data collection forms currently being used.

Strategy 2. The Regional Council will make available the DOH approved Medical Incident Report form for prehospital agencies region-wide, **OR**

Strategy 3. Develop a uniform Medical Incident Report form more suitable to the needs of the region.

VII. EVALUATION

Effectiveness of Quality Assurance

A. Data Collection and Submission: Both the Regional Council and the QI Committee support trauma registry data collection and submission. QI is provided data from the DOH for analysis of the EMS and Trauma System.

1. Needs Statement

Regional Council's Roll in Quality Improvement (QI): The Regional Council is not actively involved in regional QI. There is a position on the QI Committee for the East Region president, however the president finds it difficult to attend these meetings. In the past IPPE has been invited to attend QI meetings. IPPE involvement was limited at best. Within the last year or so, IPPE has been in attendance less and less often. Good identification of issues

Prehospital Data:
There is a definite gap in prehospital data collection statewide. The local and regional councils do not have data for system evaluation. Data submission to the regional data collection site, which provided data to both local and regional councils, was effectively halted with the clarification by DOH on mandatory prehospital data reporting and the implementation of the "new" reporting requirements on July 1, 2001 in which EMS agencies are asked to leave run sheets at trauma centers for trauma center input into registry software.

It is necessary to have good trauma data in order to effectively assess the quality of the EMS and trauma system within the region. It is also necessary to ensure consistent participation in QI Committee membership.

2. Goal 1: Trauma Data Is Available And Used For Comprehensive Regional System Review

Objective 1: Identify A Process For Making Data Available From The QI Committee To Local And Regional Councils For Review And Evaluation Of The Regional System By June 2005.

Strategy 1: Include QI reporting at the Regional Council and committee meetings where appropriate.
Strategy 2: Regional hospitals will submit quality data to the DOH in a timely manner.
Strategy 3: Collector training will be provided when a need is identified.
Strategy 4: Standardized reports for review will include 1) facility specific; 2) region specific; and 3) state comparison data.
Strategy 5: The QI Committee will review specific facility data.
Strategy 6: The QI Committee will compare East Region data between facilities as well as compare the data with Washington State Trend.

Project Cost: To Be Determined

Objective 2. ***Develop A Process For Sharing Evaluated Data For Identification And Implementation Of Changes That Improve The Outcomes For East Region Trauma Patients By June 2004.***

Strategy 1: Representative from regional QI and the Regional Council will meet to draft a process
Strategy 2: Regional Council will recommend appropriate changes to regional committees as indicated by the QI Committee.
Strategy 3: The QI Committee Chair will be invited to participate in East Region Chairs & Executive Committee meetings.

Project Cost: $5,000

Goal II: Regional Participation in QI is Consistent.

Objective 1: Seek QI committee assistance in planning QI Committee meetings that will maximize regional participation by June 2004. .

Strategy 1: Explore Video conferencing.
Strategy 2: Common issues will be identified for committee education/training purposes.
Strategy 3: QI meetings will be held every even month
Strategy 4: QI education / training will be arranged prior to meetings
Strategy 5: QI minutes and reports will be provided electronically to committee members prior to meetings.
Strategy 6: Integrate the provision of IPPE information at all regional QI meetings through the FY 04 IPPE contract with the Spokane Regional Health District **Cost: $3000**

Project Cost: To Be Determined

Submitted By: Richard P. Kness, Regional President *Date: September 2003*

Attachment 1 – East Region Patient Care Procedures

EAST REGION PATIENT CARE PROCEDURE #1
DISPATCH OF MEDICAL PERSONNEL

I. STANDARD:

1. *Licensed aid and/or licensed ambulance services shall be dispatched to all emergency medical incidents.*

2. *Verified aid and/or verified ambulance services shall be dispatched to all known injury incidents, as well as unknown injury incidents.*

3. *All licensed and verified aid and licensed and verified ambulance services shall operate 24 hours a day seven days a week. (Current WAC)*

4. *All Communication/Dispatch Centers charged with the responsibility of receiving calls for Emergency Medical Services shall develop or adopt an EMD (Emergency Medical Dispatch) Program that meets the Washington EMD Program and Implementation Guidelines.*

II. PURPOSE: (*See County Specific Operating Procedures and Response Area Maps)*

1. To provide timely care to all emergency medical and trauma patients as identified in the *Current WAC*.

2. To minimize "System Response Time" in order to get certified personnel to the scene as quickly as possible.

3. To minimize "System Response Time" in order to get licensed and or verified aid and ambulance services to the scene as quickly as possible.

4. To establish uniformity and appropriate dispatch of response agencies.

III. PROCEDURE:

1. **Following the Region's plan to promote the concept of tiered response, an appropriate licensed or verified service shall be dispatched per the above standards.**

2. **Dispatcher shall determine appropriate category of call using established Washington State EMD Guidelines.**

3. **Response shall be pre-planned by EMD response protocol. (See County Specific Operating Procedures and East Region Response Area Maps.)**

IV. DEFINITIONS

"System Response Time" for trauma means the interval from discovery of an injury until the patient arrives at the designated trauma facility. It includes:

- "Discovery Time": The interval from injury to discovery of the injury;

- "System Access Time": The interval from discovery to call received;

- "911 Time": The interval from call received to dispatch notified, including the time it takes the call answerer to:
    - Process the call, including citizen interview; and
    - Give the information to the dispatcher;

- "Dispatch Time": The interval from the call received by the dispatcher to agency notification;

- "Activation Time": The interval from agency notification to start of response;

- "Enroute Time": The interval from the end of activation time to the beginning of on-scene time;

- "Patient access time**":** The interval from the end of enroute time to the beginning of patient care;

- "On Scene Time": The interval from arrival at the scene to departure from the scene. This includes extrication, resuscitation, treatment, and loading;

- "Transport Time": The interval from leaving the scene to arrival at the health care facility.

V. QUALITY IMPROVEMENT:

The East Region Prehospital & Transportation Committee will review this PCP upon receipt of suggested modifications from a local provider, the East Region QI Committee, the Department of Health, or any other entity suggesting modifications to the document, at least biennially.

Adopted by Regional Council	6/12/96
Approved DOH	7/16/96
Implemented	7/31/96
Reviewed ER Prehospital & Transportation Committee	11/11/98 1/13/99
Adopted by Regional Council	2/10/99
Final Review PH Committee	5/17/00
Adopted DOH	5/17/00
Implemented	6/00
Reviewed ER Prehospital & Transportation Committee	2/02 3/02 4/02
Adopted Regional Council	4/02
Submitted to DOH for Approval	8/21/02
DOH Approved	10/28/02

EAST REGION PATIENT CARE PROCEDURE #2
RESPONSE TIMES

I. **STANDARD**:

All verified ambulance and verified aid services shall respond to trauma incidents in a timely manner in accordance with current WAC.

II. **PURPOSE**:

1. To provide trauma patients with appropriate and timely care.

2. To establish a baseline for data requirements needed for System Quality Improvement.

III. **PROCEDURES:**

1. The Regional Council shall work with all prehospital providers and Local Councils to identify response areas as urban, suburban, and rural or wilderness.

2. Verified ambulance and verified aid services shall collect and submit documentation to ensure the following response times are met 80% of the time; as defined in the current WAC.

	Aid Vehicle		Ambulance
Urban	**8 minutes**	**Urban**	**10 minutes**
Suburban	**15 minutes**	**Suburban**	**20 minutes**
Rural	**45 minutes**	**Rural**	**45 minutes**
Wilderness	**ASAP**	**Wilderness**	**ASAP**

3. Verified ambulance and verified aid services shall collect and submit documentation to show wilderness response times are "as soon as possible."

IV. **DEFINITIONS:**

1. **URBAN**: An unincorporated area over 30,000; or an incorporated or unincorporated area of at least 10,000 and a population density over 2,000 per square mile.

2. **SUBURBAN**: An incorporated or unincorporated area with a population of 10,000 to 29,999, or any area with a population density of 1,000 to 2,000 per square mile.

3. **RURAL**: Incorporated or unincorporated areas with total populations less than 10,000, or with a population density of less than 1,000 per square mile.

4. **WILDERNESS**: Any rural area not readily accessible by public or private road.

5.

"System Response Time" for trauma means the interval from discovery of an injury until the patient arrives at the designated trauma facility. It includes:

- "Discovery Time": The interval from injury to discovery of the injury;
- "System Access Time": The interval from discovery to call received;
- "911 Time": The interval from call received to dispatch notified, including the time it takes the call answerer to:
    - Process the call, including citizen interview; and

- Give the information to the dispatcher;

- **"Dispatch Time": The interval from the call received by the dispatcher to agency notification;**

- "Activation Time": The interval from agency notification to start of response;

- "Enroute Time": The interval from the end of activation time to the beginning of on-scene time;

- "Patient access time**":** The interval from the end of enroute time to the beginning of patient care;

- "On Scene Time": The interval from arrival at the scene to departure from the scene. This includes extrication, resuscitation, treatment, and loading;

- "Transport Time": The interval from leaving the scene to arrival at the health care facility.

V. **QUALITY IMPROVEMENT**:

The East Region Prehospital & Transportation Committee will review this PCP upon receipt of suggested modifications from a local provider, the East Region QI Committee, the Department of Health, or any other entity suggesting modifications to the document, at least biennially.

Adopted by Regional Council	6/12/96
Approved DOH	7/16/96
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EAST REGION PATIENT CARE PROCEDURE #3
TRAUMA TRIAGE AND TRANSPORT

I. STANDARD:

1. All verified ambulance verified aid services, and affiliated agencies shall comply with the Washington Prehospital Trauma Triage Procedures as defined in the current WAC. All verified ambulance services shall transport patients to the most appropriate designated facility.

2. All verified ambulance and verified aid services shall consider activating ALS rendezvous or helicopter response - Patient Care Procedure #7 - if beyond the 30 minute transport time to a designated facility.

3. Each trauma-designated facility will determine when it is appropriate to alert verified ambulance services to divert to another trauma designated facility.

II. PURPOSE:

1. To implement regional policies and procedures for all emergency medical patients and all trauma patients who meet the criteria for trauma system activation as described in the Washington Prehospital Trauma Triage Procedure.

2. To ensure that all emergency medical and/or trauma patients are transported to the most appropriate designated facility in accordance with the current WAC.

3. To allow the receiving facility adequate time to activate their emergency medical and/or trauma response team.

III. PROCEDURES:

1. The first certified EMS/TC provider determines that a patient:

   a. Needs definitive trauma care
   b. Meets the trauma triage criteria
   c. Presents with factors suggesting potential severe injury (in accordance with the Washington Prehospital Triage Procedure).

2. The provider then proceeds with primary resuscitation for the patient.

3. The provider then determines what step in the Prehospital Triage Procedure that the patient's condition/injuries meet; determination of destination is made based upon the step identified and the following:

   a. For patient meets Step 1 or Step 2 Criteria:

      1. Take the patient to the highest-level trauma center within 30 minutes transport time via ground or air transport according to DOH approved Regional Patient Care Procedures.
      2. Apply "Trauma ID Band" to the patient.

   b. Patient meets Step 3 Criteria:

      1. Take the patient to the nearest designated facility. (No change)
      2. Consult county procedure, IF:
         (a) The patient requests to bypass the nearest facility*
         (b) EMS personnel judgment suggests that the patient be taken to a higher-level facility*

3. Apply "Trauma ID Band" to the patient.

4. On-line medical control for all counties shall be accessed per COPs

5. Communication will be initiated with the receiving facility as soon as possible to allow the receiving facility adequate time to activate their emergency medical and/or trauma response team.

6. ***The receiving facility will notify the verified ambulance service about diversion according to COPs.***

7. Medical control and/or the receiving facility will be provided with the following information, as outlined in the Prehospital Destination Tool:

   a. Identification of EMS agency
   b. Vital signs. (Include First and/or Worst)
   c. Level of consciousness
   d. Anatomy of injury
   e. Biomechanics of injury
   f. Any co-morbid factors
   g. Timely updates on patient status

8. The first EMS provider to determine that a patient meets the trauma triage criteria will attach a Washington State Trauma Registry Band to the patient's wrist or ankle.

9. All information shall be documented on an appropriate medical incident report (MIR) form accepted by the County MPD, which meets trauma registry data collection requirements as outlined in WAC.

IV. QUALITY IMPROVEMENT:

The East Region Prehospital & Transportation Committee will review this PCP upon receipt of suggested modifications from a local provider, the East Region QI Committee, the Department of Health, or any other entity suggesting modifications to the document, at least biennially.

Adopted Regional Council	6/12/96
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PATIENT CARE PROCEDURE #3A
TRIAGE & TRANSPORT FOR
MEDICAL & NON-MAJOR TRAUMA PATIENTS

I. STANDARD

All licensed ambulance services shall transport patients to the most appropriate facility in accordance with County Operating Procedures (COPs).

II. PURPOSE

1. To implement regional policies and procedures for all ***medical and non-major trauma patients who do not meet the criteria for trauma system activation*** as described in the Washington Prehospital Trauma Triage Tool.

2. To ensure that all medical and/or non-major trauma patients are transported to the most appropriate facility.

III. PROCEDURES

1. Patients not meeting prehospital trauma triage criteria for activation of the trauma system, and all other patients will be transported to facilities based on County Operating Procedures (COPs).

IV. QUALITY IMPROVEMENT:

The East Region Prehospital & Transportation Committee will review this PCP upon receipt of suggested modifications from a local provider, the East Region QI Committee, the Department of Health, or any other entity suggesting modifications to the document, at least biennially.

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EAST REGION PATIENT CARE PROCEDURE #3B
PEDIATRIC TRAUMA TRIAGE & TRANSPORT

I. STANDARD

1. All verified ambulance, verified aid services, and affiliated agencies shall comply with the Washington Prehospital Trauma Triage Procedures as defined in current WAC. All verified ambulance services shall transport patients to the most appropriate designated facility.

2. All verified ambulance and verified aid services shall consider activating ALS rendezvous or helicopter response - Patient Care Procedure #7 - if beyond the 30-minute transport time to a designated facility.

3. Each trauma-designated facility will determine when it is appropriate to alert verified ambulance services to divert to another trauma designated facility.

II. PURPOSE

1. To ensure that consideration is given to early transport of a child to the regional pediatric trauma center(s) when required surgical or medical subspecialty care of resources are unavailable.

III. PROCEDURES

1. The first certified EMS/TC provider determines that a pediatric patient:

   A. Needs definitive trauma care
   B. Meets the trauma triage criteria
   C. Presents the factors suggesting potential severe injury (in accordance with the Washington Prehospital Triage Procedure)

2. The provider then proceeds with airway management and primary resuscitation for the pediatric patient.

3. Apply "Trauma ID Band" to the patient.

4. Take the pediatric patient to the highest-level pediatric trauma center within 30 minutes transport time via ground or air transport according to DOH approved regional patient care procedures and approved County Operating Procedures (COPs).

5. If a pediatric designated facility is not available within 30 minutes, take the patient to the highest adult designated facility within 30 minutes.

IV. QUALITY IMPROVEMENT:

The East Region Prehospital & Transportation Committee will review this PCP upon receipt of suggested modifications from a local provider, the East Region QI Committee, the Department of Health, or any other entity suggesting modifications to the document, at least biennially.

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PATIENT CARE PROCEDURE #4
INTERFACILITY TRANSFER OF ADULT TRAUMA PATIENTS

I. STANDARD

1. All interfacility transfers via ground or air shall be provided by the appropriate licensed and/or verified services with personnel and equipment to meet patient needs.

2. Immediately upon determination that the patient's needs exceed the scope of practice and/or their MPD approved protocols, or physician director standing orders for air ambulance's non-EMS personnel, the licensed and/or verified service personnel shall advise the facility personnel that they do not have the resources to do the transfer.

II. PURPOSE

Provide a procedure that will facilitate the goal of transferring high-risk trauma and medical patients without adverse impact to clinical outcomes or resource availability.

III. PROCEDURES

1. Medical responsibility during transport should be arranged at the time of initial contact between receiving and referring physicians. The transferring physician should write the transfer orders after consultation with the receiving physician. Facilities having transfer agreements for trauma patients are attached as a reference.

2. Prehospital MPD protocols shall be followed prior to and during transport.

3. While en-route, the transporting agency should communicate patient status and their estimated time of arrival (ETA) to the receiving facility per Medical Program Director protocols or standing orders for air ambulance's non-EMS personnel.

IV. DEFINITIONS

- **Scope of Practice**: Patient care within the scope of approved level of certification and/or specialized training.

- **Facilities** are DOH designated trauma care services.

V. QUALITY ASSURANCE

The East Region Prehospital & Transportation Committee will review this PCP upon receipt of suggested modifications from a local provider, the East Region QI Committee, the Department of Health, or any other entity suggesting modifications to the document, at least biennially.

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Reviewed ER Prehospital & Transportation Committee	11/11/98 1/13/99
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Adopted by Regional Council	6/12/02
Submitted to DOH for Approval	6/02
Revised by Prehospital, Adopted RC	6/03
DOH Approved	

PATIENT CARE PROCEDURE #5
MEDICAL GROUP SUPERVISOR AT THE SCENE

I. STANDARD:

1. *The Incident Command System shall be used.*

II. PURPOSE:

1. To define who has overall patient care responsibility at the EMS scene, and to define the line of authority when multiple agencies respond.

III. **PROCEDURE:**

1. An incident commander will designate Medical Group Supervisor or Operations Chief. When no other incident commander has been appointed the highest medical person shall be in command until a person of equal or greater training relieves him/her. EMS personnel shall direct patient care per County Operating Procedures (COPs) and Medical Program Director protocols.

2. The Medical Group Supervisor should be the individual with the highest level of medical certification who is empowered by County Operating Procedures (COPs).

3. Diversion from this PCP shall be reviewed by responding agencies, and then reported to the county MPD in the jurisdiction of the incident.

IV. QUALITY IMPROVEMENT:

The East Region Prehospital & Transportation Committee will review this PCP upon receipt of suggested modifications from a local provider, the East Region QI Committee, the Department of Health, or any other entity suggesting modifications to the document, at least biennially.

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PATIENT CARE PROCEDURE #6
EMS/MEDICAL CONTROL – COMMUNICATIONS

I. **STANDARD:**

1. *Communications between prehospital personnel and receiving facilities will utilize the most effective communications to expedite patient information exchange.*

II. **PURPOSE**:

1. To define methods of expedient communications between prehospital personnel and receiving facilities.

III. **PROCEDURE:**

1. The preferred communications method should be direct between an EMS prehospital provider and the facility. An alternative method of communications should be addressed in County Operating Procedures.

2. Local Medical Program Director, county councils and communications centers will be responsible for establishing communications procedures between the prehospital provider(s) and the facility (ies).

3. The provider agencies will maintain communications equipment and training needed to communicate in accordance with WAC.

4. Problems with communications affecting patient care will be reviewed by the provider agency, county council, MPD, communications center, and if necessary report to the Regional Communications Committee for review**.**

DEFINITION

V. **QUALITY IMPROVEMENT**:

The East Region Prehospital & Transportation Committee will review this PCP upon receipt of suggested modifications from a local provider, the East Region QI Committee, the Department of Health, or any other entity suggesting modifications to the document, at least biennially.

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Adopted by Regional Council	8/21/02
Approved by DOH	10/28/02

REGIONAL PATIENT CARE PROCEDURE #7
HELICOPTER RESPONSE

Standard:

1. *Initiate a helicopter response as soon as medically necessary.*

2. *Helicopter transport should be requested when transport time to the appropriate facility may be reduced by more than 15 minutes.*

3. *The highest level of pre-hospital EMS provider on scene may cancel the helicopter response if they determine the patient condition does not warrant air transport.*

Note: County Operating Procedures (COPS) may be added as an addendum to DOH approved PCPS to clarify implementation and operation within each county.

Purpose:

1. To define who may initiate the request for an on-scene medical helicopter and under what circumstances non-medical personnel may request on-scene helicopter service.

Procedure:

1. The highest level of pre-hospital personnel on scene may request a helicopter be placed on standby or that a helicopter(s) be launched to the scene per COPS.

Note: If the request is to place a helicopter on standby, this helicopter and crew will remain dedicated to the standby until released by the requesting agency.

2. This call shall be initiated through the appropriate medical emergency-dispatching agency per COPS. If possible, landing zone (LZ) or rendezvous sites, and/or LZ hazard assessments, should be identified at this time.

3. The helicopter service communications staff will give an approximate launch time and flight time to the dispatchers requesting service.

4. Helicopter personnel will contact ground EMS personnel as soon as possible while en-route to the scene.

5. Any citizen on scene may request a helicopter be launched to the scene. If a citizen requests a launch, the dispatching service receiving the helicopter request will assure that local EMS is dispatched to the scene at the same time.

6. After assessing the patient, if the highest level EMS personnel on scene determines that the patient's condition does not warrant air transport, they may cancel the responding helicopter and assume responsibility for patient care and transport.

7. Helicopter personnel shall follow the Incident Command System (ICS).

8. Helicopter personnel will make radio contact with the receiving hospital as soon as possible after liftoff from the scene.

Definitions:

1. **Standby: U**pon receiving the request, helicopter dispatch personnel will notify the pilot and crew of the possible flight. The crew will respond to the helicopter and load appropriate equipment. The crew will then remain at or near the helicopter until such time they are launched or released from the standby.

2. **Launch Time:** The time at which the helicopter lifts from the pad en-route to the scene. Assuming the helicopter has been on standby this will require approximately one to two minutes run-up time. Temperatures below freezing may require a little longer run-up.

3. **Flight time:** The estimated time from launch to the helicopter landing at the scene.

4. **Landing Zone (LZ) Hazard Assessment:** On-scene EMS will identify a helicopter-landing zone as close to the scene as safely possible. Ideally this will be a flat area, a minimum of 75 feet by 75 feet during daylight and 100 feet by 100 feet at night. Personnel designating the LZ must complete a hazard assessment including, but not limited to, overhead wires, rocks, uneven surfaces, loose debris, trees, vehicles, foot traffic, and high winds. Such hazards will be relayed to the pilot as the helicopter approaches the LZ.

5. **Rendezvous:** An alternate site for patient transfer from ground ambulance to air ambulance when terrain, weather, or other restraints hinder the helicopter from landing at the requested scene or hospital. The landing zone hazard assessment shall be completed for the rendezvous LZ as for any other LZ.

Quality Improvement:

. The East Region Prehospital & Transportation Committee will review this PCP upon receipt of suggested modifications from a local provider, the East Region QI Committee, the Department of Health, or any other entity suggesting modifications to the document, at least biennially.

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